DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 412, 413, 482, 485, and 486

[CMS 1131–F, CMS 1158–F, and CMS 1178–F]

RINs 0938–AK20; 0938–AK73; and 0938–AK74

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education: Fiscal Year 2002 Rates; Provisions of the Balanced Budget Refinement Act of 1999; and Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

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

ACTION: Final rules.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating and capital costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (Public Law 106–554); and implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this final rule, we describe changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes apply to discharges occurring on or after October 1, 2001. We also set forth the rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the prospective payment systems.

We are making changes to the policies governing payments to hospitals for the direct costs of graduate medical education and critical access hospitals.

Lastly, we are responding to public comments received on the following two related interim final rules that we published in the **Federal Register** and finalizing those interim rules:

• An August 1, 2000 interim final rule with comment period (65 FR 47026, HCFA–1131–IFC) that implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113), and that were effective during FY 2000. These provisions related to reclassification of hospitals from urban to rural status, reclassification of certain hospitals for purposes of payment during fiscal year 2000, critical access hospitals, payments to hospitals excluded from the prospective payment system, and payments for indirect and direct graduate medical education costs.

• A June 13, 2001 interim final rule with comment period (66 FR 32172, HCFA–1178–IFC) that implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106–554, and that were effective prior to passage of Public Law 106–554 on December 21, 2000; on April 1, 2001; or on July 1, 2001. Many of the provisions of Public Law 106–554 modified changes to the Social Security Act made by Public Law 106–113 or the Balanced Budget Act of 1997 (Public Law 105–33), or both.

EFFECTIVE DATE: The provisions of this final rule are effective October 1, 2001. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2001.

FOR FURTHER INFORMATION CONTACT: Stephen Phillips, (410) 786–4548, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, Hospital Geographic Reclassifications, Sole Community Hospitals, Disproportionate Share Hospitals, and Medicare-Dependent, Small Rural Hospitals Issues; Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education and Critical Access Hospitals Issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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

I. Background

A. Summary

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

Under section 1886(d)(1)(B) of the Act in effect without consideration of the amendments made by Public Law 105–33, Public Law 106–113, and Public Law 106–554, certain specialty hospitals are excluded from the hospital inpatient prospective payment system: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit, until the payment provisions of Public Laws 105–33, 106–113, and 106–554 that are applicable to three classes of these hospitals are implemented, as discussed below.

Various sections of Public Laws 105–33, 106–113, and 106–554 provide for the transition of rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals from being paid on an excluded hospital basis to being paid on an individual prospective payment system basis. These provisions are as follows:

• Rehabilitation Hospitals and Units. Section 1886(j) of the Act, as added by section 4421 of Public Law 105–33 and amended by section 125 of Public Law 106–113 and section 305 of Public Law 106–554, authorizes the implementation of a prospective payment system for inpatient hospital services furnished by rehabilitation hospitals and units. Section 4421 of Public Law 105–33 amended the Act by adding section 1886(j). Section 1886(j) of the Act provides for a fully implemented prospective payment system for inpatient rehabilitation hospitals and rehabilitation units, effective for cost reporting periods beginning during or after October 2002, with payment provisions during a transitional period based on target amounts specified in section 1886(b) of the Act. Section 125 of Public Law 106–113 amended section 1886(j) of the Act to require the Secretary to use a discharge as the payment unit for inpatient rehabilitation services under the prospective payment system and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow hospitals to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act. A final rule implementing the prospective payment system for inpatient rehabilitation hospitals will be published in the **Federal Register** shortly.

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

• Long-Term Care Hospitals. Sections 123(a) and (c) of Public Law 106–113 provide for the development of a per discharge prospective payment system for payment for inpatient hospital services furnished by long-term care hospitals under the Medicare program, effective for cost reporting periods beginning on or after October 1, 2002. Section 307(b)(1) of Public Law 106–554 provides that payments under the long-term care prospective payment system will be made on a prospective payment basis rather than a cost basis. The long-term care hospital prospective payment system must include a patient classification system that reflects the differences in patient resource use and costs, and must maintain budget neutrality. We are planning to develop a proposed rule, to be followed by a final rule, to implement the prospective payment system for long-term care hospitals, effective for October 1, 2002. Section 307 of Public Law 106–554 provides that if the Secretary is unable to develop a prospective payment system for long-term care hospitals that can be implemented by October 1, 2002, the Secretary must implement a prospective payment system that bases payment under the system using the existing acute hospital DRGs, modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for long-term care services.

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

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The regulations governing the acute care hospital inpatient prospective payment system are located in 42 CFR part 412. The regulations governing excluded hospitals and hospital units are located in Parts 412 and 413. The regulations governing GME payments are located in Part 413. The regulations governing CAHs are located in Parts 413 and 485.

This final rule implements amendments enacted by Public Law 106–554 relating to updates to FY 2002 payments for hospital inpatient services, hospitals' geographic reclassifications and wage indexes, GME costs, the payment adjustment for disproportionate share hospitals (DSHs), the indirect medical education (IME) adjustment for teaching hospitals, and CAHs. It also implements other changes affecting DRG classifications and relative weights, annual updates to the data used to calculate the wage index, sole community hospitals (SCHs), payments under the inpatient capital prospective payment system, and policies related to hospitals and units excluded from the prospective payment system. These changes are addressed in sections II., III., IV., and VI. of this preamble.

Section 533 of Public Law 106–554 requires the Secretary to establish a mechanism to recognize the costs of new medical services and technologies by October 1, 2001. We proposed a mechanism in the May 4, 2001 proposed rule. We received 61 comments on our proposed criteria to qualify for this special payment and on the proposed mechanism to pay for qualifying new technologies. Due to this large number of comments, we will publish a separate final rule to respond to comments received on our proposal, and to establish a mechanism, by October 1, 2001.

Although we intend to establish the mechanism by October 1, 2001, we will not make additional payments under the mechanism for cases involving new technology during FY 2002 because it is not feasible. This is due to the timing of the enactment of Public Law 106–554 on December 21, 2000, the requirement that we establish the mechanism through notice and an opportunity for public comment, and the requirement that the payments be implemented in a budget neutral manner. That is, it was not feasible to establish the criteria by which new technologies would qualify through a proposed rule with opportunity for public comment as part of the May 4, 2001 proposed rule, finalize those criteria in response to public comments, allow technologies to qualify under those criteria, and implement payments for any qualified technologies in a budget neutral manner. This is because making the special payments in a budget neutral manner requires an adjustment to the standardized amounts (which must be published in final by August 1 each year).

Representatives of new technologies seeking to qualify for special payments under this provision for FY 2003 should proceed with their application by contacting us at the telephone numbers listed in the ''For Further Information Contact'' section of this preamble. As indicated previously, a final rule containing the specific qualifying criteria and payment mechanism will be published shortly.

This final rule also responds to public comments on, and finalizes implementation of, provisions of Public Law 106–113 that relate to Medicare payments to hospitals for FY 2001 that were addressed in a separate interim final rule with comment period (HCFA–1131–IFC), published in the **Federal Register** on August 1, 2000 (65 FR 47026).

Lastly, this final rule responds to public comments on, and finalizes implementation of, other provisions of Public Law 106–554 that relate to Medicare payments to hospitals effective prior to October 1, 2001 (that is, for FY 2001 or for the period between April l, 2001 and September 30, 2001) that were addressed in a separate interim final rule with comment period (HCFA–1178–IFC), published in the **Federal Register** on June 13, 2001 (66 FR 32172).

In summary, this final rule responds to public comments on, and finalizes, three documents published in the **Federal Register:** The August 1, 2000 interim final rule with comment period, the May 4, 2001 proposed rule (HCFA–1158–P), and the June 13, 2001 interim final rule with comment period, as discussed below.

The charts below specify the effective dates of the various provisions of Public Law 106–113 and Public Law 106–554.

EFFECTIVE DATES OF THE PROVISIONS OF PUBLIC LAW 106–113 INCLUDED IN THIS FINAL RULE

Section No.	Title	Effective date
111	Indirect Medical Education Adjustment Formula	10/01/1999.
121	Wage Adjustment to Caps on Target Amounts for Excluded Hospitals and Units.	10/01/1999.
152(a)	Reclassified Hospitals in Certain Designated Counties	10/01/1999.
153	Calculation of Wage Index for Hattiesburg, Mississippi	10/01/1999.
154	Calculation of Wage Index for Allentown-Bethlehem-Easton, Pennsylvania MSA.	10/01/1999.
312	Initial Residency Period for Child Neurology Residency Programs.	7/01/2000, for residency programs that began before, on, or after 11/29/1999.
401(a)	Reclassification of Certain Urban Hospitals to Rural	01/01/2000.
401(b)(2)	Application of Reclassifications under Section 401(a) to Critical Access Hospitals.	01/01/2000.
403(a)	Length of Stay Restrictions on Inpatient Stays in Critical Access Hospitals.	11/29/1999.
403(b)	Qualifications of For-Profit Hospitals for Critical Access Hospital Status.	11/29/1999.
403(c)	Qualification of Closed Hospitals or Hospitals Downsized to Health Clinics for Critical Access Hospital Designation.	11/29/1999 for hospitals that closed after 11/29/1989; 11/29/1999 for hospitals that downsized to health clinics.
403(e)	Elimination of Medicare Part B Deductible and Coinsurance for Clinical Diagnostic Laboratory Tests Furnished in Critical Access Hospitals.	11/29/1999.
403(f)	Provisions on Swing-Beds in Critical Access Hospitals	11/29/1999.
404	Extension of Medicare-Dependent, Small Rural Hospital Program.	10/01/2002 through 9/30/2006.
407(a)	Residents on Approved Leaves of Absence—GME and IME.	11/29/1999.
407(b)	Expansion of Number of Unweighted Residents in Rural Hospitals—GME and IME.	04/01/2000.
407(c)	Urban Hospitals with Rural Training Tracks or Integrated Rural Tracks—GME and IME.	04/01/2000.
407(d)	Residents Training at Certain Veterans Hospitals—GME and IME.	10/01/1997
408(a)	Swing Beds for Skilled Nursing Facility Level of Care Patients.	07/01/1998 through the end of the facility's third cost reporting period after this date.
408(b)	Elimination of Constraints on Length of Stay in Swing Beds in Rural Hospitals.	07/01/1998 through the end of the facility's third cost reporting period after this date.
541	Additional Payments to Hospitals for Approved Nursing and Allied Health Education to Reflect Utilization of Medicare+Choice Enrollees.	01/01/2000.

EFFECTIVE DATES OF THE PROVISIONS OF PUBLIC LAW 106–113 INCLUDED IN THIS FINAL RULE

Section No.	Title	Effective date
201	Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals.	11/29/1999.
202	Assistance with Fee Schedule Payment for Professional Services under All-Inclusive Rate.	07/01/2001.
211	Threshold for Disproportionate Share Hospitals	04/01/2001.

EFFECTIVE DATES OF THE PROVISIONS OF PUBLIC LAW 106–113 INCLUDED IN THIS FINAL RULE—Continued

Section No.	Title	Effective date
212	Option to Base Eligibility for Medicare-Dependent, Small Rural Hospital Program on Discharges during Two of the Three Most Recently Audited Cost Reporting Periods.	04/01/2001.
213	Extension of Option to use Rebased Target Amounts to All Sole Community Hospitals.	10/01/2000.
301	Revision of Acute Care Hospital Payment Update for 2001	04/01/2001.
302	Additional Modification in Transition for Indirect Medical Education Adjustment.	04/01/2001.
303	Decrease in Reductions for Disproportionate Share Hospitals	04/01/2001.
304(a)	Three-Year Wage Index Reclassifications; Use of 3 Years of Wage Data for Evaluating Reclassifications.	10/01/2001.
304(b)	Statewide Wage Index for Reclassifications	10/01/2001 for reclassification beginning 10/01/2002.
304(c)	Collection of Occupational Case Mix Data	09/30/2003 for application 10/1/2004.
306	Payment for Inpatient Services of Psychiatric Hospitals	10/01/2000.
307	Payment for Inpatient Services of Long-Term Care Hospitals	10/01/2000.
511	Increase in Floor for Payments for Direct Costs of Graduate Medical Education.	10/01/2001.
512	Change in Distribution Formula for Medicare+Choice-Related Nursing and Allied Health Education Costs.	01/01/2001.
541	Increase in Reimbursement for Bad Debt	10/01/2000.

B. Summary of the Provisions of the May 4, 2001 Proposed Rule

On May 4, 2001, we published a proposed rule in the **Federal Register** (66 FR 22646) that set forth proposed changes to the Medicare hospital inpatient prospective payment system for operating and capital-related costs for FY 2002. We set forth proposed changes to the amounts and factors used in determining the rates for these costs. In addition, we proposed changes relating to payments for GME costs and payments to excluded hospitals and units, SCHs, and CAHs.

The following is a summary of the major changes that we proposed and the issues we addressed in the May 4, 2001 proposed rule:

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

As required by section 1886(d)(4)(C) of the Act, we proposed annual adjustments to the DRG classifications and relative weights. Based on analyses of Medicare claims data, we proposed to establish a number of new DRGs and make changes to the designation of diagnosis and procedure codes under other existing DRGs for FY 2002.

We also addressed the provisions of section 533 of Public Law 106–544 regarding development of a mechanism for increased payment for new medical services and technologies and the required report to Congress on expeditiously introducing new medical services and technology into the DRGs.

2. Changes to the Hospital Wage Index

We proposed to use wage data taken from hospitals' FY 1998 cost reports in the calculation of the FY 2002 wage index. We also proposed to implement the third year of the phaseout of wage costs related to GME or Part A certified registered nurse anesthetists (CRNA) from the FY 2002 wage index calculation.

We proposed several changes to the wage index methodology that would apply in calculating the FY 2003 wage index, and addressed new procedures for requesting wage data corrections and a modification of the process and timetable for updating the wage index.

- We also discussed the collection of hospital occupational mix data as required by section 304(c) of Public Law 106–554.
- In addition, we discussed revisions to the wage index based on hospital redesignations and reclassifications for purposes of the wage index, including changes to reflect the provisions of sections 304(a) and (b) of Public Law 106–554 relating to 3-year wage index reclassifications by the MGCRB, the use of 3 years of wage data for evaluating reclassification requests for FYs 2003 and later, and the application of a statewide wage index for reclassifications beginning in FY 2003.

3. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating and Graduate Medical Education Costs

We discussed several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning SCHs; rural referral centers; changes relating to the IME adjustment as a result of section 302 of Public Law 106–554; changes relating to the DSH adjustment as a result of section 303 of Public Law 106–554; the establishment of policies relating to the 3-year application of wage index reclassifications by the MGCRB, the use of 3 years of wage data in evaluating reclassification requests to the MGCRB for FYs 2003 and later, and the use of a statewide wage index for reclassifications beginning in FY 2003, as required by sections 304(a) and (b) of Public Law 106–554.

We discussed proposed requirements for qualifying for additional payments for new medical services and technology, as required by section 533(b) of Public Law 106–554.

Lastly, we proposed changes relating to payment for the direct costs of GME, including changes as a result of section 511 of Public Law 106–554.

4. Prospective Payment System for Capital-Related Costs

We proposed payment requirements for capital-related costs, including the special exceptions payment, beginning October 1, 2001.

5. Proposed Changes for Hospitals and Hospital Units Excluded from the Prospective Payment Systems

We discussed the following proposals concerning excluded hospitals and hospital units and CAHs:

- Limits on and adjustments to the proposed target amounts for FY 2002.
- Revision of the methodology for wage neutralizing the hospital-specific target amounts using preclassified wage data.
- Updated caps for new excluded hospitals and units as well as changes

in the effective date of classifications of excluded hospitals and units.

• The prospective payment system for inpatient rehabilitation hospitals and units.

• Payments to CAHs, including exclusion from the payment window requirements; the availability of CRNA pass-through payments; payment for emergency room on-call physicians; treatment of ambulance services; the use of certain qualified practitioners for preanesthesia and postanesthesia evaluations; and clarification of location requirements for CAHs.

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

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2002 prospective payment rates for operating costs and capital-related costs. We also proposed threshold amounts for outlier cases. In addition, we proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2002 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

In Appendix A, we set forth an analysis of the impact of the proposed changes on affected entities.

8. Capital Acquisition Model

In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 2002 capital cost model.

9. Report to Congress on the Update Factor for Hospitals under the Prospective Payment System and Hospitals and Units Excluded From the Prospective Payment System

In Appendix C of the proposed rule, as required by section 1886(e)(3) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2002 for payments to hospitals included in the prospective payment systems, and hospitals excluded from the prospective payment systems.

10. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix D, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2002 for the following:

• Large urban area and other area average standardized amounts (and hospital-specific rates applicable to SCHs and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.

• Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

11. Discussion of Medicare Payment Advisory Commission Recommendations

In the proposed rule, we discussed recommendations by the Medicare Payment Advisory Commission (MedPAC) concerning hospital inpatient payment policies and presented our responses to those recommendations. Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. We respond to those recommendations in section VII. of this preamble. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220 or visit MedPAC's website at: *www.medpac.gov.*

12. Public Comments Received in Response to the May 4, 2001 Proposed Rule

We received a total of 232 timely items of correspondence containing multiple comments on the proposed rule. Major issues addressed by the commenters included: additional payments for new medical services and technologies, geographic reclassifications of hospitals for purposes of the wage index, DRG reclassifications, payments for GME, and payments to CAHs.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate heading, with the exception of comments and responses pertaining to specific payments for new technologies under section 533 of Public Law 106–554. As described previously, this provision will be implemented through a separate final rule.

C. Summary of the Provisions of the August 1, 2000 Interim Final Rule with Comment Period

On August 1, 2000, we published in the **Federal Register** (65 FR 47026) an interim final rule with comment period that implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106–113, that were effective for FY 2000. The following is a summary of the policy changes we implemented as a result of Public Law 106–113:

1. Changes Relating to Payments for Operating Costs Under the Hospital Inpatient Prospective Payment System

• *Reclassification of Certain Counties.* We implemented the provisions of section 152(a) of Public Law 106–113 that reclassified hospitals in certain designated counties for purposes of making payments to affected hospitals under section 1886(d) of the Act for FY 2000. The counties affected by this provision are identified under section III. of this preamble.

• *Wage Index.* We implemented sections 153 and 154 of Public Law 106–113 that contain provisions affecting the wage indexes of specific Metropolitan Statistical Areas (MSA). Under section 153, the Hattiesburg, Mississippi FY 2000 wage index was calculated including wage data from Wesley Medical Center. Under section 154, the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index was calculated including wage data for Lehigh Valley Hospital.

• *Reclassification of Certain Urban Hospitals as Rural Hospitals.* We implemented section 401 of Public Law 106–113 which directed the Secretary to treat certain hospitals located in urban areas as being located in rural areas of their State if the hospital meets statutory criteria and files an application with HCFA. This provision was effective on January 1, 2000.

• *IME Adjustment.* We implemented section 111 of Public Law 106–113 which provided for an additional payment to teaching hospitals equal to the additional amount the hospitals would have been paid for FY 2000 if the IME adjustment formula (which reflects the higher indirect operating costs associated with GME) for FY 2000 had remained the same as for FY 1999.

• *Extension of the MDH Provision.* We implemented section 404 of Public Law 106–113 which extended the MDH program and its current payment methodology for an additional 5 years, from FY 2002 through FY 2006.

2. Additional Changes Relating to Direct GME and IME

• *Initial Residency Period for Child Neurology Residency Programs.* We implemented section 312 of Public Law 106–113 which provides that in determining the number of residents for purposes of GME and IME payments, the period of board eligibility and the initial residency period for child neurology is the period of board

eligibility for pediatrics plus 2 years. This provision is effective on or after July 1, 2000, for residency programs that began before, on, or after November 29, 1999.

• *Residents on Approved Leaves of Absence.* We implemented section 407(a) of Public Law 106–113 which provides that, for purposes of determining a hospital's full-time equivalent (FTE) cap for direct GME payments and the IME adjustment, a hospital may count an individual to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. The provision relating to direct GME was effective with cost reporting periods beginning on or after November 29, 1999. The provision relating to the IME adjustment applied to discharges occurring in cost reporting periods beginning on or after November 29, 1999.

• *Expansion of Number of Unweighted Residents in Rural Hospitals.* We implemented section 407(b) of Public Law 106–113 which provides that a rural hospital's resident FTE count for direct GME and IME may not exceed 130 percent of the number of unweighted residents that the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996. The provision relating to direct GME applied to cost reporting periods beginning on or after April 1, 2000. The provision relating to the IME adjustment applied to discharges occurring on or after April 1, 2000.

• *Urban Hospitals with Rural Training Tracks or Integrated Rural Tracks.* We implemented section 407(c) of Public Law 106–113 which allows an urban hospital that establishes separately accredited approved medical residency training programs (or rural training tracks) in a rural area or has an accredited training program with an integrated rural track to receive an FTE cap adjustment for purposes of direct GME and IME. The provision was effective with cost reporting periods beginning on or after April 1, 2000, for direct GME, and with discharges occurring on or after April 1, 2000, for IME.

• *Residents Training at Certain Veterans Affairs Hospitals.* We implemented section 407(d) of PublicLaw 106–113 which provides that a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who were training at a VA hospital and were transferred on or after January 1, 1997, and before July 31, 1998, to the non-VA hospital because the program at the VA hospital would lose its accreditation by the Accreditation Council on Graduate Medical Education if the residents continued to train at the facility. This provision applies as if it was included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning on or after October 1, 1997, and for IME, for discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

3. Payments for Nursing and Allied Health Education: Utilization of Medicare+Choice Enrollees

We implemented section 541 of Public Law 106–113 which provides an additional payment to hospitals that receive payments under section 1861(v) of the Act for approved nursing and allied health education programs associated with services to Medicare+Choice enrollees. This provision is effective for portions of cost reporting periods occurring on or after January 1, 2000.

4. Changes Relating to Hospitals and Hospital Units Excluded From the Prospective Payment System

We implemented section 121 of Public Law 106–113 which amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1999.

5. Changes Relating to CAHs

We implemented—

• Section 401(b) of Public Law 106–113, which contained conforming changes to incorporate the reclassifications made by section 401(a) of Public Law 106–113 to the CAH statute (section 1820(c)(2)(B)(i) of the Act). This provision is effective beginning on January 1, 2000.

• Section 403(a) of Public Law 106–113, which deleted the 96-hour length of stay restriction on inpatient care in a CAH and authorized a period of stay that does not exceed, on an annual, average basis, 96 hours per patient. This provision is effective beginning on November 29, 1999.

• Section 403(b) of Public Law 106–113, which allows for-profit hospitals to qualify for CAH status. This provision is effective beginning on November 29, 1999.

• Section 403(c) of Public Law 106–113, which allows hospitals that have closed within 10 years prior to November 29, 1999, or hospitals that downsized to a health clinic or health center, to be designated as CAHs if they satisfy the established criteria for designation, other than the requirement for existing hospital status.

• Section 403(e) of Public Law 106–113, which eliminated the Medicare Part B deductible and coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis. This provision is effective with respect to services furnished on or afterNovember 29, 1999.

• Section 403(f) of Public Law 106–113, entitled ''Participation in Swing Bed Program,'' which amended sections 1883(a)(1) and (c) of the Act.

6. Changes Relating Hospital to Swing Bed Program

We implemented section 408(a) of Public Law 106–113 which eliminated the requirement for a hospital to obtain a certification of need to use acute care beds as swing beds for skilled nursing facility (SNF) level of care patients; and section 408(b) of Public Law 106–113 which eliminates constraints on the length of stay in swing beds for rural hospitals with 50 to 100 beds. These provisions were effective on the first day after the expiration of the transition period for prospective payments for covered SNF services under the Medicare program (that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date).

We received a total of eight timely items of correspondence containing multiple comments on the August 1, 2000 interim final rule with comment period. Summaries of the public comments received and our responses to those comments are set forth below under the appropriate section headings of this final rule.

D. Summary of the Provisions of the June 13, 2001 Interim Final Rule With Comment Period

On June 13, 2001, we published an interim final rule with comment period in the **Federal Register** (66 FR 32172) that implemented changes to the Act affecting Medicare payments to hospitals for inpatient services that were made by Public Law 106–554. Some of these changes were effective before the December 21, 2000 date of enactment of Public Law 106–554, on April 1, 2001,

or on July 1, 2001. The changes, on which we requested public comment, are as follows:

1. Changes Relating to Payments for Operating Costs Under the Hospital Inpatient Prospective Payment System

• *Treatment of Rural and Small Urban Disproportionate Share Hospitals (DSHs)* . We implemented the provisions of section 211 of Public Law 106–554 which lowered thresholds by which certain classes of hospitals qualify for DSH payments, with respect to discharges occurring on or after April 1, 2001.

• *Decrease in Reductions for DSH Payments*. We implemented section 303 of Public Law 106–554 which modified the previous reduction in the DSH payment to be 2 percent in FY 2001 and 3 percent in FY 2002.

• *Medicare-Dependent, Small Rural Hospitals (MDHs)*. We implemented section 212 of Public Law 106–554 which provided an option to base eligibility for MDH status on discharges during two of the three most recently audited cost reporting periods, effective with cost reporting periods beginning on or after April 1, 2001.

• *Revision of Prospective Payment System Standardized Amounts.* We implemented section 301 of Public Law 106–554 which revised the update factor increase for the inpatient prospective payment rates for FY 2001.

• *Indirect Medical Education Adjustment (IME).* We implemented section 302 of Public Law 106–554 which provided that for the purposes of making the IME payment for discharges occurring on or after April 1, 2001 and before October 1, 2001, the adjustment will be determined as if the adjustment equaled a 6.75 percent increase in payment for every 10 percent increase in the resident-to-bed ratio, rather than a 6.25 percent increase.

• *SCHs*. We implemented section 213 of Public Law 106–554 which further extended the 1996 rebasing option, for hospital cost reporting periods beginning October 1, 2000, to all SCHs and provides that this extension is effective as if it had been included in section 405 of Public Law 106–113.

2. Payments for Nursing and Allied Health Education: Utilization of Medicare+Choice Enrollees

We implemented section 512 of Public Law 106–554 which revised the formula for determining the additional payment amounts to hospitals for Medicare+Choice nursing and allied health education costs to specifically account for each hospital's Medicare+Choice utilization.

3. Changes Relating to Payments for Capital-Related Costs Under the Hospital Inpatient Prospective Payment System

As a result of implementing section 301 of Public Law 106–554, which provided increased inpatient operating payment rates, we recalculated the unified outlier threshold for inpatient operating and inpatient capital-related costs. Therefore, we revised the capital outlier offset which also required us to revise the capital-related rates.

4. Changes Relating to Hospitals and Hospital Units Excluded From the Prospective Payment System

• *Increase in the Incentive Payment for Excluded Psychiatric Hospitals and Units*. We implemented section 306 of Public Law 106–554, which provided that for cost reporting periods beginning on or after October 1, 2000, for psychiatric hospitals and units, if the allowable net inpatient operating costs do not exceed the hospital's ceiling, payment is the lower of: (1) net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or, (2) net inpatient costs plus 3 percent of the ceiling.

• *Increase in the Wage Adjusted 75th Percentile Cap on the Target Amounts for Long-Term Care Hospitals*. We implemented section 307(a) of Public Law 106–554, which provided a 2-percent increase to the wage-adjusted 75th percentile cap on the target amount for long-term care hospitals, effective for cost reporting periods beginning during FY 2001.

• *Increase in the Target Amounts for Long-Term Care Hospitals*. We implemented section 307(a) Public Law 106–554, which provided a 25 percent increase to the target amounts for long-term care hospitals for cost reporting periods beginning in FY 2001, up to the cap on target amounts.

5. Changes Relating to CAHs

• *Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH*. We implemented section 201(a) of Public Law 106–554, which amended section 1834(g) of the Act to state that there will be no collection of coinsurance, deductible, copayments, or any other type of cost sharing from Medicare beneficiaries with respect to outpatient clinical diagnostic laboratory services furnished as outpatient CAH services and that those services will be paid for on a reasonable cost basis.

• *Assistance with Fee Schedule Payment for Professional Services under All-Inclusive Rate*. We implemented section 202 of Public Law 106–554, which amended section 1834(g)(2)(B) of the Act to provide that when a CAH elects to be paid for Medicare outpatient services under the reasonable costs for facility services plus fee schedule amounts for professional services method, Medicare will pay 115 percent of the amount it otherwise pays for the professional services.

• *Condition of Participation with Hospital Requirements at the Time of Application for CAH Designation (§ 485.612)*. We implemented a conforming change to correct § 485.612 to reflect that certain entities are not required to have a provider agreement prior to CAH designation.

6. Other Inpatient Costs

• *Increase in Reimbursement for Bad Debts.* We implemented section 541 of Public Law 106–554 which provided a 30 percent decrease of allowable hospital bad debt reimbursement for cost reporting periods beginning during FY 2001 and all subsequent fiscal years. This section modified section 4451 of Public Law 105–33 that reduced the total allowable bad debt reimbursement for hospitals by 45 percent.

We received a total of 13 timely pieces of correspondence containing comments on the June 13, 2001 interim final rule with comment period. A summary of these public comments and our responses to them are set forth under sections IV. and VI. of this final rule.

II. Changes to DRG Classifications and Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGS.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes

in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 2001 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). Medicare fiscal intermediaries enter the information into their claims processing systems and subject it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

In version 18 of the GROUPER (used for FY 2001), cases are assigned to one of 499 DRGs (including one DRG (469) for a diagnosis that is invalid as a discharge diagnosis and one DRG (470) for ungroupable diagnoses) in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)).

In general, cases are assigned to an MDC, based on the principal diagnosis, before assignment to a DRG. However, there are six DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for heart, liver, bone marrow, and lung transplants (DRGs 103, 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders individual procedures or groups of procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (CC).

Generally, the GROUPER does not consider other procedures. That is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

We proposed numerous changes to the DRG classification system for FY 2002. The proposed changes, the public comments we received concerning them, and the final DRG changes are set forth below. Unless otherwise noted, the changes we are implementing will be effective in the revised GROUPER software (Version 19.0) to be implemented for discharges on or after October 1, 2001. Unless noted otherwise, we are relying on the data analysis in the proposed rule for the changes discussed here.

Chart 1 lists the changes we are making by adding new DRGs or removing old DRGs. Chart 2 summarizes the changes we are making with respect to the reassignment of procedure codes. Chart 3 presents the changes we are making to the titles of existing DRGs.

In Chart 2 of the proposed rule, several procedure codes were erroneously included in the ''Removed from DRG'' column of the chart (66 FR 22650). The 11 affected codes are 37.21, 37.22, 37.23, 37.26, 88.52, 88.53, 88.54, 88.55, 88.56, 88.57, and 88.58. Inclusion of these codes in this chart made it appear as if the codes were being deleted from DRG 104. In fact, they are being additionally assigned to DRG 514. We have corrected Chart 2 in this final rule.

CHART 1.—SUMMARY OF CHANGES IN DRG ASSIGNMENTS

Diagnosis related groups (DRGs)	Added as new	Removed
Pre-MDC:		
DRG 512 (Simultaneous Pancreas/Kidney Transplant)	X	
DRG 513 (Pancreas Transplants)	X	
MDC 5 (Diseases and Disorders of the Circulatory System):		
DRG 112 (Percutaneous Cardiovascular Procedures)		X
DRG 514 (Cardiac Defibrillator Implant with Cardiac Catheterization)	X	
DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization)	X	
DRG 516 (Percutaneous Cardiovascular Procedures with Acute Myocardial Infarction (AMI))	X	
DRG 517 (Percutaneous Cardiovascular Procedures without AMI, with Coronary Artery Stent Implant	X	
DRG 518 (Percutaneous Cardiovascular Procedures without AMI, without Coronary Artery Stent Implant	X	
MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue):		
DRG 519 (Cervical Spinal Fusion with CC)	X	
DRG 520 (Cervical Spinal Fusion without CC)	X	
MDC 20 (Alcohol/Drug Use and Alcohol/Drug-Induced Organic Mental Disorders):		
DRG 434 (Alcohol/Drug Abuse or Dependency, Detoxification or Other Symptomatic Treatment with CC)		X
DRG 435 (Alcohol/Drug Abuse or Dependency, Detoxification or Other Symptomatic Treatment without CC)		X
DRG 436 (Alcohol/Drug Dependence with Rehabilitation Therapy)		X
DRG 437 (Alcohol/Drug Dependence, Combined Rehabilitation and Detoxification Therapy)		X
DRG 521 (Alcohol/Drug Abuse or Dependence with CC)	X	

CHART 1.—SUMMARY OF CHANGES IN DRG ASSIGNMENTS—Continued

Diagnosis related groups (DRGs)	Added as new	Removed
DRG 522 (Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation Therapy)	X	
DRG 523 (Alcohol/Drug Abuse or Dependence without CC, without Rehabilitation Therapy)	X	

CHART 2.—SUMMARY OF ASSIGNMENT OR REASSIGNMENT OF DIAGNOSIS OR PROCEDURE CODES IN EXISTING DRGS

Diagnosis/procedure codes	Removed from DRG	Reassigned to DRG
MDC 5 (Diseases and Disorders of the CirculatorySystem)		
Principal Diagnosis Code:		
410.01 Acute myocardial infarction of anterolateral wall, initial episode of care	116	516.
410.11 Acute myocardial infarction of other anterior wall, initial episode of care	116	516.
410.21 Acute myocardial infarction of inferolateral wall, initial episode of care	116	516.
410.31 Acute myocardial infarction of inferoposterior wall, initial episode of care	116	516.
410.41 Acute myocardial infarction of other inferior wall, initial episode of care	116	516.
410.51 Acute myocardial infarction of other lateral wall, initial episode of care	116	516.
410.61 True posterior wall infarction, initial episode of care	116	516.
410.71 Subendocardial infarction, initial episode of care	116	516.
410.81 Acute myocardial infarction of other specified sites, initial episode of care	116	516.
410.91 Acute myocardial infarction of unspecified site, initial episode of care	116	516
Procedure Codes:		
37.94 Implantation or replacement of automatic cardioverter/defibrillation, total system (AICD)	104, 105	514, 515.
37.95 Implantation of automatic cardioverter/defibrillator lead(s) only	104, 105	514, 515.
37.96 Implantation of automatic cardioverter/defibrillator pulse generator only	104, 105	514, 515.
37.97 Raplacement of automatic cardioverter/defibrilator lead(s) only;	104, 105	514, 515.
37.98 Replacement of automatic cardioverter/defibrillator pulse generator only	104, 105	514, 515.
Operating Room Procedures:		
35.96 Percutaneous valvuloplasty	112, 116	516, 517, 518.
36.01 Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy without mention of thrombolytic agent.	112, 116	516, 517, 518.
36.02 Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy with mention of thrombolytic agent.	112, 116	516, 517, 518.
36.05 Multiple vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent.	112, 116	516, 517, 518.
36.09 Other removal of coronary artery obstruction	112, 116	516, 517, 518.
37.34 Catheter ablation of lesion or tissues of heart	112, 116	516, 517, 518.
92.27 Implantation or insertion of radioactive elements	non-OR in MDC–5	517
Nonoperating Room Procedures:		
36.06 Insertion of coronary artery stent(s)	116	517.
37.26 Cardiac electrophysiologic stimulation and recording studies	112	514, 516, 517, 518.
37.27 Cardiac mapping	112	516, 517, 518.
MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)		
Procedure Codes:		
81.02 Other cervical fusion, anterior technique	497, 498	519, 520.
81.03 Other cervical fusion, posterior technique	497, 498	519, 520.
MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)		
Diagnosis Codes:		
770.7 Chronic respiratory disease arising in the perinatal period	387, 389	92, 93.
773.0 Hemolytic disease due to RH isoimmunization	387, 389	390.
773.1 Hemolytic disease due to ABO isoimmunization	387, 389	390.
Secondary Diagnosis Codes:		
478.1 Other diseases of nasal cavity and sinuses	390	391.
520.6 Disturbances in tooth eruption	390	391.
623.8 Other specified noninflammatory disorders of vagina	390	391.
709.00 Dyschromia, unspecified	390	391.
709.01 Vitiglio	390	391.
709.09 Dyschromia, Other	390	391.
744.1 Accessory Auricle	390	391.
754.61 Congenital pes planus	390	391.
757.33 Congenital pigmentary anomalies of skin	390	391.
757.39 Other specified anomaly of skin	390	391.
764.08 ''Light for dates'' without mention of fetal malnutrition, 2,000–2,499 grams	390	391.
764.98 Fetal growth retardation, unspecified, 2,000–2,499 grams	390	391.
772.6 Cutaneous hemorrhage	390	391.
779.3 Feeding problems in newborns	390	391
794.15 Abnormal and auditory function studies	390	391.

CHART 2.—SUMMARY OF ASSIGNMENT OR REASSIGNMENT OF DIAGNOSIS OR PROCEDURE CODES IN EXISTING DRGS—Continued

Diagnosis/procedure codes	Removed from DRG	Reassigned to DRG
796.4 Other abnormal clinical findings	390	391.
V20.2 Routine infant or child health check	390	391.
V72.1 Examination of ears and hearing	390	391.

CHART 3.—SUMMARY OF RETITLED DRGS

MDC	DRG No.	Current name	New name
MDC 5	DRG 116	Other Permanent Cardiac Pacemaker Implantation, or PTCA, with Coronary Artery Stent Implant.	Other Cardiac Pacemaker Implantation.
MDC 8	DRG 497	Spinal Fusion with CC	Spinal Fusion except Cervical with CC.
MDC 8	DRG 498	Spinal Fusion without CC	Spinal Fusion except Cervical with CC.

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

a. Removal of Defibrillator Cases from DRGs 104 and 105

DRGs 104 (Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization) and 105 (Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization) include the replacement or open repair of one or more of the four heart valves. These valves may be diseased or damaged, resulting in either leakage or restriction of blood flow to the heart, compromising the ability of the heart to pump blood. This procedure requires the use of a heart-lung bypass machine, as the heart must be stilled and opened to repair or replace the valve.

Cardiac defibrillators are implanted to correct episodes of fibrillation (very fast heart rate) caused by malfunction of the conduction mechanism of the heart. Through implanted cardiac leads, the defibrillator mechanism senses changes in heart rhythm. When very fast heart rates occur, the defibrillator produces a burst of electric current through the leads to restore the normal heart rate. An implanted defibrillator constantly monitors heart rhythm. The implantation of this device does not require the use of a heart-lung bypass machine, and would be expected to be very different in terms of resource usage, although both procedures currently group to DRGs 104 and 105.

For the proposed rule, as part of our ongoing review of DRGs, we examined Medicare claims data on DRG 104 and DRG 105. We reviewed 100 percent of the FY 2000 MedPAR file containing hospital bills received through May 31, 2000, for discharges in FY 2000, and found that the average charges across all cases in DRG 104 were $84,060, while the average charges across all cases in DRG 105 were $66,348. Carving out code 37.94 (Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]) from DRGs 104 and 105 increased those average charges to $91,366 for DRG 104 and $67,323 for DRG 105. We identified 11,021 defibrillator cases in DRG 104 (out of 25,112 total cases), with average charges of $74,719, and 2,434 defibrillator cases in DRG 105 (out of 20,094 total cases), with average charges of $59,267.

We performed additional review on cases containing code 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only) with code 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only) and on cases containing code 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only) with code 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only). This subgrouping contained only 56 patients. The average charges for the 18 patients in DRG 104 were $58,847. The average charges for the 38 patients in DRG 105 were $54,891.

In the proposed rule, because we believed the defibrillator cases are significantly different from other cases in DRGs 104 and 105, we proposed two new DRGs: DRG 514 (Cardiac Defibrillator Implant with Cardiac Catheterization) and DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization).

We also proposed the removal of procedure codes 37.94, 37.95 and 37.96, and 37.97 and 37.98 from DRGs 104 and 105 to form the new DRGs 514 and 515.

We received 58 comments on this proposal.

Comment: Many commenters noted that implanted cardioverter defibrillators (ICDs) or AICDs are lifesaving devices that demonstrate state-of-the-art technology for the treatment of cardiac arrhythmias by continuously monitoring, analyzing, and, if needed, restoring a patient's normal heart rhythm.

One commenter described the technology. Similar to the size of a pacemaker, the ICD is placed under the skin of the upper chest. It has the capacity to continuously monitor and analyze a patient's heart rhythm. If the ICD detects an arrhythmia, it can terminate the abnormal rhythm with either a pacemaker function or the delivery of a low-energy electrical shock to restore normal heart rhythm.

Response: We agree that ICDs and AICDs are an important addition to the treatment of cardiac disease. The creation of DRGs 514 and 515 is not meant to effect a judgement call about the efficacy or importance of this treatment, but simply to attempt to improve the accuracy of payments within MDC 5, based on the actual charge data associated with these cases.

Comment: A vast majority of the commenters expressed concern that payments associated with defibrillators will decrease for FY 2002 as a result of this change, with some commenters noting that an ICD or AICD may cost the hospital between $22,000 and $25,000 per device. The commenters stated that if this is the case, there is a limited amount for the remainder of the hospital care (for example, operating room, supplies, nursing staff salary, and typically a 7-day stay in an intensive care unit). Most commenters called for

additional analysis prior to implementation of DRGs 514 and 515.

Response: As we described in the proposed rule and above, DRGs 104 and 105 currently include many different procedures, with a range of costs associated with these different procedures. We proposed to change the assignment of cardiac defibrillators to new DRGs 514 and 515 to more accurately pay for the more expensive procedures remaining in DRGs 104 and 105, as well as to improve the payment accuracy for cardiac defibrillators. In fact, the relative weight of DRG 104 increases from FY 2001 to FY 2002 by 9.1 percent.

Comment: Many commenters argued that using hospital charges to determine DRG relative weights can give a distorted picture of the costs of a procedure. The commenters referred to an unspecified national database indicating that the average mark-up of charges over cost for ICDs is lower than the mark-up applied to other components of care. Other commenters referred to the March 2001 Report to Congress by the MedPAC, which, in the context of evaluating available data for setting accurate relative values, stated that hospitals' billed charges ''give a distorted picture of relative costliness across DRGs because they reflect systematic differences among hospitals in the average mark-up of charges over costs'' (page 11).

Several commenters stated that about 66 percent of hospitals are losing $5,000 or more per case for these procedures. These commenters did not understand why payment would be reduced even further in light of those losses.

Response: Hospital charges have been the basis for recalibrating the DRG relative weights since FY 1986 (see 50 FR 24372 and 50 FR 35652). To the extent that the mark-up of charges over costs varies from one particular device or procedure to another, the relative weights will be impacted. However, due to the relativity of the DRG weights, a low mark-up associated with one device or procedure will be offset by relatively higher mark-ups associated with another device or procedure, leading to higher relative weights, and thus higher payments, for the latter device or procedure. The prospective payment system is an average-based payment methodology, where hospitals are expected to offset any losses they may incur from any individual or group of cases with payment gains incurred from other cases.

Furthermore, hospital charges are determined by each hospital on an item-by-item basis. It is not possible to account for these individual management decisions in the process of developing a national payment system based on prospectively determined average payment rates.

As demonstrated in the impact analysis in Appendix A to this final rule, hospital payments would rise (prior to the budget neutrality adjustment) by 0.3 percent as a result of all of the DRG changes we are implementing in this final rule, including this change. In addition, we note that the latest analysis by MedPAC indicates the average hospital Medicare inpatient operating margin during FY 1999 (the latest year available) was 12.0 percent (Report to the Congress: Medicare Payment Policy, page 64). Therefore, we believe that hospitals will be able to adequately adjust to these payment changes in both the short and the long term.

Comment: One commenter noted that the adjustment to DRGs 104 and 105 as reflected in Table 5, ''List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay,'' in the Addendum of the proposed rule, does not reflect the resource consumption as discussed above. The commenter recommended that we increase the relative weights to reflect the resource consumption of DRGs 104 and 105.

Response: In this final rule, the relative weight for DRG 104 is 7.8411 for FY 2002, an increase of 9.1 percent from FY 2001. The relative weight for DRG 105 in this final rule is 5.6796 for FY 2002, a 0.4 percent increase from FY 2001. These percentage changes are very similar to the percent change in average charges in DRGs 104 and 105 after removing ICD and AICD charges, as described above. We note that the final relative weight values are based on 100 percent of FY 2000 discharges in the MedPAR database as of March 2001. The analysis using average charges described above was based on an earlier sample of cases; therefore, the percentage changes do not match exactly.

Comment: Other commenters noted that this change, and the resulting increase in payments for procedures remaining in DRGs 104 and 105, is a positive step to improving the payment for heart assist devices. However, the commenters were disappointed that we did not take the opportunity to make a similar revision for cases involving mechanical heart assist devices.

Response: As described above, removing the ICDs/AICDs from DRGs 104 and 105 will have the net effect of increasing the relative weights for both DRGs, so payment for the remaining cases will increase. We will continue to evaluate our options for improving the accuracy of our payments for heart assist technologies.

After carefully reviewing all of the comments submitted, we have decided to proceed with the creation of two new DRGs to capture cases involving the implantation of cardiac defibrillators. The new DRGs 514 and 515 include principal diagnosis codes and procedure codes as reflected in Chart 4 below:

CHART 4.—COMPOSITION OF NEW DRGS 514 AND 515 IN MDC 5

Diagnosis and procedure codes	Included in DRG 514	Included in DRG 515
Principal Diagnosis Codes:		
All of the principal diagnosis codes assigned to MDC–5	X	X
Principal or Secondary Procedure Code:		
37.94 Implantation or replacement of automatic cardioverter/defibrillator, total system (AICD)	X	X
Combination Operating Procedure Codes:		
37.95 Implantation of automatic cardioverter/defibrillator lead(s) only;		
Plus		
37.96 Implantation of automatic cardioverter/defibrillator pulse generator only;	X	X
Or		
37.97 Replacement of automatic cardioverter/defibrillator lead(s) only;		
Plus		
37.98 Replacement of automatic cardioverter/defibrillator pulse generator only	X	X
Plus: One of the Following Nonoperating Room ProcedureCodes:		
37.21 Right heart cardiac catheterization	X	
37.22 Left heart cardiac catheterization	X	

CHART 4.—COMPOSITION OF NEW DRGS 514 AND 515 IN MDC 5—Continued

Diagnosis and procedure codes		Included in DRG 514	Included in DRG 515
37.23	Combined right and left heart cardiac catheterization	X	
37.26	Cardiac electrophysiologic stimulation and recording studies	X	
88.52	Angiocardiography of right heart structures	X	
88.53	Angiocardiography of left heart structures	X	
88.54	Combined right and left heart angiocardiography	X	
88.55	Coronary arteriography using a single catheter	X	
88.56	Coronary arteriography using two catheters	X	
88.57	Other and unspecified coronary arteriography	X	
88.58	Negative-contrast cardiac roentgenography	X	

b. Percutaneous Cardiovascular Procedures

In the May 4 proposed rule, we indicated that we had reviewed other DRGs within MDC 5 in order to determine if there were also logic changes that could be made to these DRGs. The data were arrayed in a variety of ways displaying myriad permutations, resulting in the following proposed changes.

A percutaneous transluminal coronary angioplasty (PTCA) is an acute intervention intended to minimize cardiac damage by restarting circulation to the heart. Some patients with an acute myocardial infarction (AMI) are now treated by performing a PTCA during the hospitalization for the AMI. Currently, PTCAs with a coronary stent implant are assigned to DRG 116 (Other Permanent Cardiac Pacemaker Implantation, or PTCA with Coronary Artery Stent Implant), along with pacemaker implants. The remaining percutaneous cardiovascular procedures are assigned to DRG 112 (Percutaneous Cardiovascular Procedures).

The volume of percutaneous cardiovascular procedures has grown dramatically, with 186,669 cases identified in the FY 2000 MedPAR file containing hospital bills submitted through May 31, 2000. Because of the high volume, we decided to review the DRG for percutaneous cardiovascular procedures. As a first step in the evaluation, we combined the percutaneous cardiovascular procedures from DRGs 112 and 116. We then subdivided the combined percutaneous cardiovascular procedure group into two groups based on the principal diagnosis (Pdx) of AMI.

Group	Count	Average charge
With Pdx of AMI	50,442	$31,722
Without Pdx of AMI	136,227	23,989

Each of these groups was further evaluated by subdividing them based on whether a coronary stent was implanted. The vast majority of patients with an AMI had a coronary stent implanted. Patients without an AMI were subdivided into two groups based on whether a coronary stent was implemented.

Group	Count	Average charge
Without Pdx of AMI with stent	111,441	$24,745
Without Pdx of AMI without stent	24,786	20,589

In the proposed rule, based on this analysis, we proposed the removal of PTCAs with coronary artery stent from DRG 116, thus limiting DRG 116 to permanent cardiac pacemaker implantation. This removal would leave approximately 68,000 non-PTCA cases in DRG 116.

In conjunction with this evaluation, we considered a new technology, intravascular brachytherapy, that is being used to treat coronary in-stent stenosis. A gamma-radiation-impregnated tape is threaded through the affected vessel for a specified amount of dwell time, and then the tape is removed. Intravascular brachytherapy was approved by the Food and Drug Administration in November 2000.

Intravascular brachytherapy is assigned to procedure code 92.27 (Implantation or insert of radioactive elements). With the use of angioplasty, these cases are currently assigned to DRG 112 (Percutaneous Cardiovascular Procedures). Therefore, cases involving this new technology will be implicated by these changes.

Also in the proposed rule, we proposed to retitle DRG 116 ''Other Cardiac Pacemaker Implantation,'' remove DRG 112, and create three new DRGs: DRG 516 (Percutaneous Cardiovascular Procedures with Acute Myocardial Infarction (AMI)); DRG 517 (Percutaneous Cardiovascular Procedures without AMI, with Coronary Artery Stent Implant); and DRG 518 (Percutaneous Cardiovascular Procedures without AMI, without Coronary Artery Stent Implant). In order to be assigned to new DRG 516, cases must contain one of the principal diagnoses *plus* the operating room procedures listed in Chart 5. Because DRG 516 contains acute myocardial infarction, which is hierarchically ordered before DRGs 517 and 518, any AMI cases also containing codes 92.27 or 36.06 (Insertion of coronary artery stents(s)) would automatically be assigned to DRG 516. We also proposed the assignment of patients with a percutaneous cardiovascular procedure and intravascular radiation treatment to new DRG 517. As more data become available, we will reassess the assignment of intravascular radiation treatment to DRG 517. New DRG 518 would contain the same operating room and nonoperating room procedures as new DRG 517, with the exception of codes 92.27 and 36.06. We received 10 comments on this proposal.

Comment: Several commenters supported the reclassification of percutaneous vascular procedures to DRGs within this MDC. Other commenters, however, stated the proposed changes would be inappropriate because they would reduce payment overall for percutaneous cardiovascular procedures. These commenters noted that new technologies associated with these procedures are, in fact, more costly rather than less costly. In addition, commenters expressed concern that payment for pacemakers under DRG 116 would be reduced from FY 2001 levels.

Response: Based on 100 percent of FY 2000 discharges on file through March 2001, we estimate the case-weighted average relative weight for DRGs 116, 516, 517 and 518 to be 2.2236, a 4.5 percent decline from the case-weighted average relative weight for DRGs 112 and 116 for FY 2001 (2.3280). As discussed above in relation to the new DRGs 514 and 515, the calculation of

the relative weights reflects the charges submitted by hospitals for these cases.

Comment: Five commenters addressed only the inclusion of code 92.27 (Implantation or insertion of radioactive elements, also known as brachytherapy) in new DRG 517 in cases without presence of AMI (these cases would go to DRG 516 if AMI were present). Four of the five expressed appreciation for this change, citing its clinical appropriateness and increased payment, which is close to the additional facility costs for performing the procedure.

One commenter, while commending the decision to assign these cases to DRG 517, requested clarification about our decisionmaking process in assigning this technology to the same DRG as coronary stents. The commenter requested that we outline the specific criteria we applied or the process we followed to evaluate the adequacy of the external data submitted.

Response: Although we received external data from a manufacturer of this technology, they were not the basis for our decision, as we were unable to verify the data because the data were submitted too late in the process of preparing the FY 2002 proposed rule. When we proposed to restructure DRGs 112 and 116, our decision was based on the clinical coherence of the DRGs. Intravascular radiation treatment is an invasive procedure that requires an additional 35 to 45 minutes, and requires the services of both a radiation (nuclear) physicist and a radiation safety officer in the operating room, as well as specifically trained operating room personnel, such as an ultrasound specialist.

Comment: One commenter wrote that these changes fail to account for the use of GP IIB–IIIA inhibitors for cases with acute coronary syndromes. The commenter was concerned whether the DRG assignment for these cases under the proposed DRGs would be appropriate.

Response: The administration of GP IIB–IIIA inhibitors is through intravenous infusion, and is assigned to code 99.20 (Injection or infusion of platelet inhibitor). The GROUPER does not recognize code 99.20 as a procedure and, therefore, its presence does not affect DRG assignment. As described above, the DRG assignment for these cases under the newly configured DRGs 116, 516, 517, and 518 would be determined by the presence of AMI and the presence of other procedures that would cause the case to group to one of the other DRGs besides 518. Our analysis of FY 2000 MedPAR data indicates that, among cases with code 99.20 currently assigned to either DRGs 112 or 116 for FY 2000, the majority of these cases are currently assigned to DRG 116 (317,108 discharges compared to 52,945). Therefore, the majority of these cases involve procedures that do affect DRG assignment. We will continue to evaluate these cases, however, to determine whether further revisions would be appropriate.

Comment: One commenter indicated that codes 37.27 (Cardiac mapping) and 37.34 (Catheter ablation of lesion or tissues of heart) would now be grouped to new DRGs 516, 517, and 518. Because these procedures are not usually used on patients with AMI or patients who receive a stent, the commenter indicated the cases would most likely be grouped to DRG 518. The commenter believed that we were unaware that certain procedures, such as the two previously mentioned, have greater resource utilization than other percutaneous cardiovascular procedures that do not involve AMI or stents. The commenter asserted that this is an inadvertently inappropriate classification. The commenter recommended that CMS either create a separate DRG for cardiac mapping and ablation procedures, or else assign codes 37.27 and 37.34 to DRG 516 after retitling the DRG appropriately.

Response: These cases previously were assigned to either DRG 112 or 116, depending upon whether they involved the insertion of a stent or the implantation of a pacemaker. This GROUPER assignment logic did not change, although the presence or absence of AMI is now a factor as well. We believe this is an appropriate clinical categorization. However, we will consider this issue as we continue to evaluate these DRGs.

The principal diagnosis codes and operating room and nonoperating room procedure codes that are included in the new DRGs 516, 517, and 518 are reflected in Chart 5.

CHART 5.—COMPOSITION OF NEW DRGS 516, 517, AND 518 IN MDC 5

Diagnosis and procedure codes	Included in DRG 516	Included in DRG 517	Included in DRG 518
Principal Diagnosis Codes:			
410.01 Acute myocardial infarction of anterolateral wall, initial episode of care	X		
410.11 Acute myocardial infarction of other anterior wall, initial episode of care	X		
410.21 Acute myocardial infarction of inferolateral wall, initial episode of care	X		
410.31 Acute myocardial infarction of inferoposterior wall, initial episode of care	X		
410.41 Acute myocardial infarction of other inferior wall, initial episode of care	X		
410.51 Acute myocardial infarction of other lateral wall, initial episode of care	X		
410.61 True posterior wall infarction, initial episode of care	X		
410.71 Subendocardial infarction, initial episode of care	X		
410.81 Acute myocardial infarction of other specified sites, initial episode of care	X		
410.91 Acute myocardial infarction of unspecified site, initial episode of care	X		
Plus:			
Operating Room Procedures:			
35.96 Percutaneous valvuloplasty	X	X	X
And			
36.01 Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy without mention of thrombolytic agent	X	X	X
Or			
36.02 Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy with mention of thrombolytic agent	X	X	X
Or			
36.05 Multiple vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent	X	X	X

CHART 5.—COMPOSITION OF NEW DRGS 516, 517, AND 518 IN MDC 5—Continued

Diagnosis and procedure codes	Included in DRG 516	Included in DRG 517	Included in DRG 518
And			
36.09 Other removal of coronary artery obstruction	X	X	X
And			
37.34 Catheter ablation of lesion or tissues of heart	X	X	X
92.27 Implantation or insertion of radioactive elements	.....	X	.....
Or:			
Nonoperating Room Procedures:			
36.06 Insertion of coronary artery stent(s)	.....	X	.....
37.26 Cardiac electrophysiologic stimulation and recording studies	X	X	X
37.27 Cardiac mapping	X	X	X

DRG 121 (Circulatory Disorders with AMI and Major Complication, Discharged Alive), DRG 122 (Circulatory Disorders with AMI without Major Complication, Discharged Alive), and DRG 123 (Circulatory Disorders with AMI, Expired) are not affected by these changes.

c. Removal of Heart Assist Systems

The ICD–9–CM Coordination and Maintenance Committee considered the nonoperative removal of heart assist systems at its November 17, 2000 meeting. A device called the intra-aortic balloon pump (IABP) is one of the most common types of ventricular assist systems. A balloon catheter is placed into the patient's descending thoracic aorta, and inflates and deflates with each heartbeat. This device is timed with the patient's own heart rhythm, and inflates and circulates blood to the heart and other organs. This allows the heart to rest and recover. The IABP may be used preoperatively, intraoperatively, or postoperatively. It supports the patient from a few hours to several days.

Code 37.64 (Removal of heart assist system) already exists, and it is considered by the GROUPER to be an operative procedure. However, the nonoperative removal of a heart assist system can be done at the patient's bedside, is noninvasive, and requires no anesthesia. Therefore, the Committee created code 97.44 (Nonoperative removal of heart assist system) for use with discharges beginning on or after October 1, 2001.

In the past, we have assigned new ICD–9–CM codes to the same DRG to which the predecessor code was assigned. In the proposed rule, we explained that if this practice were to be followed, we would have proposed that code 97.44 be assigned to MDC 5, DRGs 478 (Other Vascular Procedures with CC) and 479 (Other Vascular Procedures without CC). After hospital charge data became available, we would have considered moving it to other DRGs. However, in accordance with section 533(a) of Public Law 106–554, which requires a more expeditious technique of recognizing new medical services or technology for the hospital inpatient prospective payment system, we will reconsider this longstanding practice when possible. Therefore, as code 97.44 was designed to capture heart assist system removal that is clearly nonoperative, we did not propose to designate 97.44 as a code which the GROUPER recognizes as a procedure. The GROUPER will assign these cases to a medical DRG based on the principal diagnosis, or to a surgical DRG if a surgical procedure recognized by the GROUPER is performed. This assignment can be found in Table 6B, New Procedure Codes, in the Addendum to this rule.

We received no comments on this proposal. However, we did receive comments on another issue in MDC 5, relating to DRGs 110 and 111 (Major Cardiovascular Procedures with and without CC).

Comment: One commenter submitted a case study on stent technology, noting that Medicare payments in their facility were 31.4 percent lower than total costs. This commenter made no recommendations, but stated that often surgeons must use additional stent segments to repair aneurysms, increasing total costs by thousands of dollars.

Response: We do not have a clear understanding of the commenter's statement that often surgeons must use additional stent segments to repair aneurysms, thereby increasing total costs. We are unclear because the device presented to us for new ICD–9–CM code consideration was proposed as a single device, custom-fitted to the patient's needs. We will continue to monitor this technology and the new code (used for discharges on or after October 1, 2001).

Comment: One commenter noted that aortic endografts are assigned to DRGs 110 and 111, and the cost of the device alone is greater than the entire payment for DRG 111. The commenter noted that this is a straightforward issue, and recommended that these cases be assigned specifically to DRG 110.

Response: DRGs 110 and 111 are what we refer to as paired DRGs. Paired DRGs are exactly the same as each other with regard to the principal diagnosis and procedure codes in most cases. However, other aspects of the patient's case have a bearing on DRG assignment, such as the patient's age or the secondary diagnoses (which determine comorbidities or complications in appropriate DRGs). In this case, DRGs 110 and 111 are divided based on the presence or absence of secondary diagnosis codes. If there are no secondary diagnosis codes present, the case will be assigned to DRG 111. It has been our experience that patients not having secondary diagnoses are less expensive for the hospital to treat, thereby resulting in a lower weighted DRG assignment.

Hospitals should code their records completely, recording and submitting all relevant diagnosis and procedure codes having a bearing on the current admission. As noted previously, payment for each DRG is based on the average charges for cases assigned to that DRG as submitted to us by hospitals.

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

a. Refusions

We have received questions from correspondents regarding the appropriateness of the spinal fusion DRGs: DRG 496 (Combined Anterior/Posterior Spinal Fusion); DRG 497 (Spinal Fusion with CC); and DRG 498 (Spinal Fusion without CC). Several correspondents expressed concern about the inclusion of all refusions of the spine into one procedure code, 81.09 (Refusion of spine, any level or technique). The correspondents pointed out that because all refusions using any technique or level are in this one code,

all of these cases are assigned to DRG 497 and DRG 498. They also pointed out that fusion cases involving both an anterior and posterior technique are assigned to DRG 496. Although cases with the refusion code that involve anterior and posterior techniques would appear to be more appropriately assigned to DRG 496, this is not the case.

We recognized this limitation in the refusion codes and further acknowledged that this limitation in the ICD–9–CM coding system creates DRG problems by preventing the assignment to DRG 496 even when both anterior and posterior techniques are used for refusion cases. Therefore, we referred the issue to the ICD–9–CM Coordination and Maintenance Committee and requested the Committee to consider code revisions for the refusions of the spine during its year 2000 public meetings.

After its deliberations, the Committee approved a series of new procedure codes for refusion of the spine that could lead to improvements within DRGs 497 and 498. These new codes, listed below, go into effect on October 1, 2001.

81.30 Refusion of spine, not otherwise specified
81.31 Refusion of atlas-axis spine
81.32 Refusion of other cervical spine, anterior technique
81.33 Refusion of other cervical spine, posterior technique
81.34 Refusion of dorsal and dorsolumbar spine, anterior technique
81.35 Refusion of dorsal and dorsolumbar spine, posterior technique
81.36 Refusion of lumbar and lumbosacral spine, anterior technique
81.37 Refusion of lumbar and lumbosacral spine, lateral transverse process technique
81.38 Refusion of lumbar and lumbosacral spine, posterior technique
81.39 Refusion of spine, not elsewhere classified

As previously stated, all refusions of the spine and corrections of the pseudarthrosis of the spine are assigned to code 81.09. Code 81.09, which is always assigned to DRG 497 or DRG 498, includes refusions at any level of the spine using any technique. With the creation of the new procedure codes listed above, it will be possible to determine the level of the spine at which the refusion is performed, as well as the technique used, and assign the case to a more appropriate DRG.

These new procedure codes should greatly improve our ability to determine the level and technique used in the refusion.

In the past, we have assigned new ICD–9–CM codes to the same DRG to which the predecessor code was assigned. In the proposed rule, we explained that if this practice were followed, these new codes would have been assigned to DRG 497 and 498 as they are currently. After data became available, we would have considered moving them to other DRGs. However, in accordance with section 533(a) of Public Law 106–554, which requires more expeditious methods of recognizing new medical services or technology under the inpatient hospital prospective payment system, we will reconsider this longstanding practice when possible. Since the new codes clearly allow us to identify cases where the technique was either anterior or posterior and these cases are clinically similar and, therefore, should be handled in the same fashion, we proposed to immediately assign these cases on the same basis as the fusion codes (81.00 through 81.09). We would not wait for actual claims data before making this change. These assignments are reflected in Chart 6 and also can be found in Table 6B, in section V. of the Addendum to this final rule.

Comment: One commenter supported the creation of the ICD–9–CM codes for refusions as well as their proposed DRG assignments.

Response: We appreciate the support of the commenter and are adopting the proposed DRG assignments for refusions of spine as final.

b. Fusion of Cervical Spine

In the proposed rule we discussed an inquiry concerning the spinal DRGs that focused on fusions of the cervical spine. The inquirer stated that there was a significant difference between inpatients who undergo anterior cervical spinal fusion and other types of spinal fusion in regard to treatment, recovery time, costs, and risk of complications. Anterior cervical spinal fusions are assigned to procedure code 81.02 (Other cervical fusion, anterior technique). The inquirer pointed out that anterior cervical fusions differ significantly from anterior techniques at other levels since the anatomic approach is far less invasive. Thoracic anterior techniques require working around the cardiac and respiratory systems in the chest cavity, while lumbar anterior techniques require working around bowel and digestive system and the abdominal muscles. The inquirer recommended that code 81.02 be removed from DRGs 497 and 498 and grouped separately.

We analyzed claims data from the FY 2000 MedPAR file containing hospital bills received through May 31, 2000, and confirmed that charges are lower for fusions of the cervical spine than fusions of the thoracic and lumbar spine. This was true for both anterior and posterior cervical fusions of the spine. Our medical consultants agree that the data and their clinical analysis support the creation of new DRGs for cervical fusions of the spine. We proposed to remove procedure codes 81.02 and 81.03 from the spinal fusion DRGs (currently, DRGs 497 and 498) and assign them to new DRGs for cervical spinal fusion with and without CC. We also proposed four groupings for fusion DRGs. The net effect of this change is an increase in the weights for DRGs 497 and 498, since the lower charges for the cervical fusions would be removed. The average standardized charge for all spinal fusions with CCs was $26,957. For all spinal fusions without CCs, the average charge was $16,492. The table below also shows average standardized charges for these types of cases before and after the revisions.

Revised spinal fusion DRGs	Average charge before revisions	Average charge after revisions
DRG 497 Spinal Fusion Except Cervical with CC	$26,957	$36,821
DRG 498 Spinal Fusion Except Cervical without CC	17,492	26,297
DRG 519 Cervical Spinal Fusion with CC	.....	26,957
DRG 520 Cervical Spinal Fusion without CC	.....	16,492

Based on the groupings, we proposed the creation of two new DRGs: DRG 519 (Cervical Spinal Fusion with CC); and DRG 520 (Cervical Spinal Fusion without CC). The procedure codes that would be included in the DRGs 519 and 520 are reflected in Chart 6 below.

We also proposed to add the new ICD–9–CM procedure codes for refusion of the cervical spine (81.32 and 81.33) to the new cervical spine fusion DRGs because they are clinically similar.

In addition, we proposed to retitle DRG 497 ''Spinal Fusion Except Cervical with CC'' and DRG 498 ''Spinal Fusion Except Cervical without CC.'' The retitled DRGs 497 and 498 would retain fusion codes 81.00, 81.01, and 81.04 through 81.08 and include the new refusion codes 81.30, 81.31, and 81.34 through 81.39, as reflected in Chart 6 below.

Comment: One commenter commended the creation of the new ICD–9–CM codes for spinal refusions and the development of the new DRGs for cervical fusions. This commenter, a manufacturer of devices used for spinal fusions, agreed that cervical fusions on average cost less than lumbar and thoracic fusions. Another commenter who supported the creation of the new DRGs mentioned that this classification would more appropriately reflect the resources used in the varying cases.

Two commenters asserted that DRGs 497 and 498 fail to take into account the cost variations when multi-level spinal fusions are performed. The commenters stated that the cost and complexity of a discharge varies substantially depending on the number of levels performed as part of a fusion procedure. Commenters recommended that new ICD–9–CM procedure codes be created for multi-level spine procedures to track and measure costs. The current ICD–9–CM codes do not differentiate between the number of levels that are fused. The commenter defined multi-level as three or more vertebral segments, either anterior or posterior, or both. In addition, the commenter recommended that these new multi-level fusion codes be assigned to the higher weighted DRG 496. The commenter recommended that DRG 496 be renamed ''Multi-Level Spine Procedure Anterior and/or Posterior for Stabilization and/or Correction and/or Refusion.''

Response: We agree that the current ICD–9–CM procedure codes do not differentiate between the number of levels fused. This proposal will be addressed by the ICD–9–CM Coordination and Maintenance Committee at its November 1, 2001 meeting. A potential problem with this recommendation will be the need to avoid overlapping codes. The current fusion codes are based on an axis of the level of the fusion (cervical or lumbar) and an additional axis of the approach (anterior, posterior, or lateral transverse). Devising a modified or additional scheme that utilizes an additional axis of the number of disks fused may be quite challenging. If this scheme requires the use of a set of codes from the new Chapter 17, we could quickly use up these currently empty codes. As far as the recommendation to include these new multi-level fusion codes in DRG 496, this issue will be deferred until after the coding issue is addressed. If new codes are created, they will be included in an upcoming proposed rule along with their proposed DRG assignment.

Since there was support for the proposed changes to the spinal DRGs, these will be implemented as final changes effective October 1, 2001.

c. Posterior Spinal Fusion

We received other correspondence regarding the current DRG assignment for code 81.07, Lumbar and lumbosacral fusion, lateral transverse process technique. The correspondent stated that physicians consider code 81.07 to be a posterior procedure. The patient is placed prone on the operating table and the spine is exposed through a vertical midline incision. The correspondent pointed out that code 81.07 is not classified as a posterior procedure within DRG 496 (Combined Anterior/Posterior Spinal Fusion). Therefore, when 81.07 is reported with one of the anterior techniques fusion codes, it is not assigned to DRG 496. The correspondent recommended that code 81.07 be added to the list of posterior spinal fusion codes for use in determining assignment to DRG 496.

In the proposed rule, we indicated that we consulted with our clinical advisors and they agreed that this addition should be made. Since we proposed to handle the new refusion codes in the same manner as the fusion codes, we also proposed to assign DRG 496 when 81.37 is used with one of the anterior technique fusion or refusion codes. This would be similar to the manner in which code 81.07 is classified. For assignment to DRG 496, we would consider codes 81.02, 81.04, 81.06, 81.32, 81.34, and 81.36 to be anterior techniques and codes 81.03, 81.05, 81.07, 81.08, 81.33, 81.35, and 81.38 to be posterior techniques.

CHART 6.—REVISED COMPOSITION OF DRGS 496, 497, AND 498 AND COMPOSITION OF DRG 519 AND 520 IN MDC 8

Diagnosis and procedure codes	Existing DRG 496		Retained in or Added to existing DRG 497	Retained in or Added to existing DRG 498	Included in DRG 519 included in DRG 520	
	Assigned as anterior techniques	Assigned as posterior techniques				
Principal or Secondary Procedure Codes:						
81.00 Spinal fusion, not otherwise specified	.....	.....	X	X	.....	.....
81.01 Atlas-axis fusion	.....	.....	X	X	.....	.....
81.02 Other cervical fusion, anterior technique	X	.....	.....	.....	X	X
81.03 Other cervical fusion, posterior technique	.....	X	.....	.....	X	X
81.04 Lumbar and lumbosacral fusion, anterior technique	X	.....	X	X	.....	.....
81.05 Lumbar and lumbosacral fusion, posterior technique	.....	X	X	X	.....	.....
81.06 Lumbar and lumbosacral fusion, anterior technique	X	.....	X	X	.....	.....
81.07 Lumbar and lumbosacral fusion, lateral transverse process technique	.....	X	X	X	.....	.....
81.08 Lumbar and lumbosacral fusion, posterior technique	.....	X	X	X	.....	.....

CHART 6.—REVISED COMPOSITION OF DRGS 496, 497, AND 498 AND COMPOSITION OF DRG 519 AND 520 IN MDC 8—Continued

Diagnosis and procedure codes	Existing DRG 496		Retained in or Added to existing DRG 497	Retained in or Added to existing DRG 498	Included in DRG 519 included in DRG 520	
	Assigned as anterior techniques	Assigned as posterior techniques				
81.30 Refusion of spine, not otherwise specified			X	X		
81.31 Refusion of atlas-axis spine			X	X		
81.32 Refusion of other cervical spine, anterior technique	X				X	X
81.33 Refusion of other cervical spine, posterior technique		X			X	X
81.34 Refusion of dorsal and dorsolumbar spine, anterior technique	X		X	X		
81.35 Refusion of dorsal and dorsolumbar spine, posterior technique		X	X	X		
81.36 Refusion of lumbar and lumbosacral spine, anterior technique	X		X	X		
81.37 Refusion of lumbar and lumbosacral spine, posterior technique		X	X	X		
81.38 Refusion of lumbar and lumbosacral spine, posterior technique		X	X	X		
81.39 Refusion of spine, not elsewhere classified			X	X		

There was no opposition expressed to the changes proposed for posterior spinal fusions; therefore, we are adopting the proposed changes as final.

d. Spinal Surgery

The California Division of Workers' Compensation notified us of a possible problem with the following spinal DRGs:

DRG 496 (Combined Anterior/Posterior Spinal Fusion)
DRG 497 (Spinal Fusion with CC)
DRG 498 (Spinal Fusion without CC)
DRG 499 (Back & Neck Procedures except Spinal Fusion with CC)
DRG 500 (Back & Neck Procedures except Spinal Fusion without CC)

The Division of Workers' Compensation uses the DRG categories developed by CMS to classify types of hospital care. However, instead of using CMS' weights for determining reimbursement for inpatient services, the Division sets a global fee for all inpatient medical services not otherwise exempted. This fee is established by multiplying the product of the DRG weight (or revised DRG weight for a small number of categories) and the health facility's composite factor by 1.20 to get the maximum amount for worker compensation admissions.

The Division of Workers' Compensation has received reports that the formula it uses for reimbursing cases may be providing inadequate reimbursement. California hospitals and orthopedists have reported that certain spinal surgery DRGs (DRGs 496 through 500) may involve different types of care and/or technologies than those in use at the time these groups were formulated. Health care providers in California report ''recent increased use of the new implantation devices, hardware, and instrumentation, coupled with requirements for intensive hospital services accompanying use of new procedures, has led to inadequate reimbursement in these DRGs.'' As a short-term response to these concerns, the California Division of Workers' Compensation is exempting the costs of hardware and instrumentation from the global fee of the fee schedule for DRGs 496 through 500. The Division also requested that CMS examine these DRGs for any potential problem under the Medicare reimbursement system.

The ICD–9–CM coding system does not capture specific types of implantation devices, hardware, and instrumentation. Therefore, we were not able to verify the claim that these new devices have led to increased costs in specific cases. We believe that the adoption of a more detailed coding system, such as ICD–10–PCS, would supply greater amounts of detail on these items. However, in the short term, it is not possible to identify a specific problem that involves implantation devices, hardware, and instrumentation.

Comment: As previously stated, we received support for the proposed changes to the spinal fusion DRGs. As was also stated, one commenter pointed out that the current ICD–9–CM codes do not specify the number of levels fused, nor do they specify the types of devices used.

One commenter, who manufactures spinal fusion devices, commended the new ICD–9–CM codes for refusions and the new DRGs for cervical fusions. This commenter also requested new codes specifying the number of levels fused. The commenter stated that typically two devices are used per level and therefore, with increased levels, there would be an increase in the number of infusion devices. The commenter recommended new codes for multi-level spinal fusions, but did not recommend new codes that would specify particular types of devices.

Responses: This coding issue will be addressed at future meetings of the ICD–9–CM Coordination and Maintenance Committee. If new codes are created, their DRG assignment would be addressed in a subsequent proposed rule.

4. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract)

We have received correspondence from a manufacturer of an implantable vascular device requesting that code 86.07 (Insertion of totally implantable vascular access device [VAD]) be assigned as an operative procedure in MDC 11, to DRG 315 (Other Kidney & Urinary Tract O.R. Procedures). This request was inadvertently omitted from the May 4, 2001 proposed rule. Therefore, we are taking this opportunity to discuss possible designation of this procedure code as a code affecting DRG assignment in MDC 11.

Procedure code 86.07 describes the implantation of a VAD into the chest wall and blood vessels of a patient's upper body. Patients requiring this particular device have been diagnosed with renal (kidney) failure. Insertion of a VAD allows access to the patient's blood for dialysis purposes when other sites for hemodialysis have been exhausted. According to representatives from the manufacturer of one particular VAD used for hemodialysis, this device costs the hospitals $1,750, and is usually inserted in the outpatient setting as opposed to admission for insertion of the device.

The GROUPER program does not recognize code 86.07 as a procedure in other than MDC 9 (Disease and Disorders of the Skin, Subcutaneous Tissue and Breast), in DRGs 269 and 270 (Other Skin, Subcutaneous Tissue & Breast Procedure, with and without CC). Therefore, its presence in any other MDC does not affect DRG assignment. Patients who are admitted with renal failure and who have a VAD inserted will be assigned to DRG 316 (Renal Failure), absent any other surgical procedures. DRG 316 is a medical DRG with a lower relative weight than cases in the surgical DRGs within the same MDC.

We extensively reviewed the MedPAR data. We found that code 86.07 appeared in 358 different DRGs. Of these 358 DRGs, 173 include additional procedures recognized by GROUPER and are therefore considered surgical, while 185 are medical. Because of the space limitations of the ICD–9–CM, code 86.07 is used to describe VAD devices used for other purposes than hemodialysis.

We looked specifically at the cases within DRGs 315 and 316 as shown in the two tables below:

DRG 315 (SURGICAL)

	With code 86.07	Without code 86.07
Number of Cases	421	19,815.
Average Length of Stay	12.5 days	6.8 days.
Average Charges	$39,946	$23,061.

DRG 316 (MEDICAL)

	With code 86.07	Without code 86.07
Number of Cases	1,020	19,815.
Average Length of Stay	10.2 days	6.6 days.
Average Charges	$27,730	$15,045.

Cases containing code 86.07 have higher average lengths of stay as well as higher average charges than cases not containing this code. We further examined the total number of reported procedures, as well as the range of average charges across both DRGs, for cases containing code 86.07. Both DRGs contain a significant number of additional procedures. The nature of these procedures varies widely, including such divergent procedures as X-rays and scans, injections, dental extraction, cardiac catheterization, aneurysm repair, and laparoscopic cholecystectomy. We also identified 24 cases in DRG 315 and 28 cases in DRG 316 with multiple insertions of the VAD. We believe those instances where the VAD is inserted as an inpatient procedure involve cases where other complications exist, leading to the higher average charges noted above. We are not assigning code 86.07 to DRG 315 as a surgical procedure, but will continue to consider possible alternative specifications of these DRGs.

Additionally, we take this opportunity to clarify correct coding practice. It has come to our attention that a brochure is being distributed with the product that advocates coding insertion of the Lifesite® Hemodialysis Access System using ICD–9–CM procedure code 86.07 in addition to code 39.93 (Insertion of vessel-to-vessel cannula). Inclusion of code 39.93 will force these cases into DRG 315, the higher weighted surgical DRG. Our data review showed 33 such cases of double coding. We would caution hospitals that the use of code 39.93, in the absence of the actual procedure, is erroneous. According to our vascular surgeon consultant, the LifeSite® Hemodialysis Access System as presented to us is not a vessel-to-vessel cannula. It is a device inserted into a vessel. Therefore, providers submitting code 39.93 without the actual procedure having been performed are at risk for review of fraudulent coding practice and DRG upcoding.

This same product brochure contains the name and telephone number of a nationally recognized coding specialist. The addition of this specialist's name and number was included without her knowledge or consent. We take this opportunity to reiterate that LifeSite® Hemodialysis Access System is correctly coded using 86.07 alone.

5. MDC 12 (Diseases and Disorders of the Male Reproductive System)

At its May 11, 2000 public meeting, the ICD–9–CM Coordination and Maintenance Committee considered a request from a manufacturer to create a unique code for the procedure Penile plethysmography with nerve stimulation in DRG 334 (Major Male Pelvic Procedures with CC). The penile plethysmography is a test that can be performed during a radical prostatectomy procedure. During the course of the procedure, the physician places a probe within an area where the prostatic nerves are thought to be located and is able to detect minor changes in penile tumescence or detumescence. This reaction tells the physician that the nerve bundles have been located, which may aid the physician in performing a nerve-sparing radical prostatectomy procedure with precision. The nerve bundles can also be restimulated at the conclusion of the procedure, providing immediate feedback as to whether erectile function will be restored after surgery.

After a presentation on the nerve identifying procedure and review of existing ICD–9–CM codes, the ICD–9–CM Coordination and Maintenance Committee determined that the existing

code 89.58 (Plethysmogram) adequately describes this test.

Radical prostatectomies for patients with cancer of the prostate are grouped in either DRG 334 (Major Male Pelvic Procedures with CC) or DRG 335 (Major Male Pelvic Procedures without CC). We have received a request from a manufacturer of a nerve-identifying device to assign cases containing code 89.58 into DRG 334 only, not into DRG 335. DRG 334 results in higher payments to hospitals. For FY 2002, DRG 334 has a relative weight of 1.5177, and DRG 335 has a relative weight of 1.1047. The manufacturer requested that we designate code 89.58 as an operating room procedure code that would be recognized by the GROUPER software, and make that code applicable only to DRG 334. The manufacturer believed that this would serve to take any cases of nerve sparing out of the lower paying DRG 335, and would make the technology more attractive to hospitals. As paired DRGs 334 and 335 are currently structured, they differ only in whether or not a secondary diagnosis identified as a CC is recorded.

We examined those cases in DRG 334 to which the procedure code for prostatectomy was assigned. Of the total 7,241 cases in DRG 334 identified, 5,611 of these cases contained procedure code 60.5 (Radical prostatectomy). Only three of the prostatectomy cases included code 89.58. There are not a sufficient number of cases on which to base an assessment of the payment for this procedure. Therefore, we did not propose to modify the assignment of code 89.58.

We received one comment on this proposal.

Comment: The commenter argued that the analysis conducted on the procedure code assignment of 89.58 was incomplete, as it did not include evaluation of DRG 335 in the calculations. The commenter added that DRG also includes radical prostatectomies for patients with cancer of the prostate.

Response: We apologize for the omission. Our review of data on DRG 335 showed that the DRG contained 8,125 total cases. There were 8,117 cases that did not contain procedure code 89.58; these cases had average total charges of $12,808. There were 8 cases in this group containing code 89.58. These 8 cases had average total charges of $16,366. We found a subset of 7,050 cases containing procedure code 60.5; these cases had average total charges of $12,772. Within this subset, only 7 cases were reported containing codes 60.5 and 89.58. These 7 cases had average total charges of $16,593.

Even including these additional cases, we identified very few cases in our analysis. Therefore, we are adopting as final our original proposed decision not to modify the assignment of code 89.58 by assigning it exclusively to DRG 334 within MDC 12. However, we will continue to monitor this procedure to determine whether a change in DRG assignment is warranted in the future.

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

DRG 390 (Neonate with Other Significant Problems) contains newborn or neonate cases with other significant problems not assigned to DRGs 385 through 389, DRG 391, or DRG 469. To be assigned to DRG 389 (Full Term Neonate with Major Problems), the neonate must have one of the principal or secondary diagnosis listed under this DRG. A neonate is assigned to DRG 390 when the neonate has a principal or secondary diagnosis of newborn or neonate with other significant problems that are not assigned to DRG 385 through 389, 391, or 469.

We have received correspondence suggesting a number of changes to be made to DRGs 398 and 391. These changes involve removing two codes from DRG 389 and adding 17 codes to DRG 391, as described below.

a. DRG 389 (Full Term Neonate with Major Problems)

The correspondent suggested removing the following codes from DRG 389 and assigning them to DRG 390:

773.0 Hemolytic disease due to RH isoimmunization

773.1 Hemolytic disease due to ABO isoimmunization

The correspondent stated that hemolytic disease due to RH isoimmunization or due to ABO isoimmunization should not be considered a major problem. The correspondent recommended that these two conditions be classified as significant problems instead and thus assigned to DRG 390.

Our medical consultants sought additional advice from the National Association of Children's Hospitals and Related Institutions (NACHRI). (CMS contracts with the 3M Health Information Systems to maintain the DRG system. The medical experts at 3M evaluate proposed DRG changes from a clinical perspective. These medical consultants assist CMS in evaluating alternative proposals.) NACHRI and our medical consultants agree that it is appropriate to remove codes 773.0 and 773.1 from DRG 389. Therefore, we proposed to remove 773.0 and 773.1 from DRG 389 so that neonates with these conditions are assigned to DRG 390.

Comment: Several commenters supported the proposed revisions for newborns within MDC 15. One commenter stated that the code assignments mentioned in the proposed rule are more appropriately classified based on their clinical attributes. Another commenter agreed with the proposed changes, but requested that an additional code be added to those being moved to DRG 391 (Normal Newborn). Specifically, the commenter requested that code 779.3, Feeding problems in newborns, be listed under DRG 391. Currently, when this code is listed as a secondary code, it results in the assignment of the neonate to DRG 390. The commenter stated that this condition and its resource consumption should not cause the neonate to be classified under DRG 390.

Response: We discussed this additional issue with our medical consultants and they agreed that code 779.3 should also be listed under DRG 391. They concurred that the addition of this code as a secondary diagnosis should not lead to the newborn being classified as having a significant problem. Therefore, code 779.3 will be included among the codes being moved to DRG 391 as of October 1, 2001.

Comment: One commenter suggested that codes 773.0 and 773.1 be removed from DRG 387 (Prematurity with major problems) in addition to DRG 389. The list of major problems in DRGs 389 and 387 mirror each other. The only difference is that DRG 387 includes premature newborns. The commenter asked us to consider codes 773.0 and 773.1 as significant problems for newborns and classify them into DRG 390, which would make them applicable for premature and full-term newborns.

Response: We agree with the commenter. We are removing codes 773.0 and 773.1 from DRG 389 as well as DRG 387. This removal will result in these cases being assigned to DRG 390 (Neonate with Other Significant Problems).

b. DRG 391 (Normal Newborn)

We also have received correspondence with recommendations for changes to DRG 391. The correspondent pointed out that the following secondary codes currently lead to the assignment of the neonate to DRG 390 (Neonate with Other Significant Problems). The correspondent believed that the conditions described by these codes

should not cause the neonate to be classified under DRG 390 when reported as a secondary diagnosis. The correspondent recommended that these conditions be listed under DRG 391 (Normal Newborn).

478.1 Other diseases of nasal cavity and sinuses
520.6 Disturbances in tooth eruption
623.8 Other specified noninflammatory disorders of vagina
709.00 Dyschromia, unspecified
709.01 Vitiglio
709.09 Dyschromia, Other
744.1 Accessory auricle
754.61 Congenital pes planus
757.33 Congenital pigmentary anomalies of skin
757.39 Other specified anomaly of skin
764.08 ''Light for dates'' without mention of fetal malnutrition, 2,000–2,499 grams
764.98 Fetal growth retardation, unspecified, 2,000–2,499 grams
772.6 Cutaneous hemorrhage
794.15 Abnormal and auditory function studies
796.4 Other abnormal clinical findings
V20.2 Routine infant or child health check
V72.1 Examination of ears and hearing

Our medical consultants also sought the advice of NACHRI on this recommendation. NACHRI reviewed the list of codes and agreed that none of these conditions should be considered to be a significant problem for a neonate. NACHRI concurred that neonates with these secondary diagnoses should be classified as normal newborns. Therefore, we proposed to add the codes listed above to DRG 391 and not classify them to DRG 390 when reported as a secondary diagnosis.

Comment: One commenter expressed concern that the weights assigned to five newborn DRGs (DRGs 385, 368, 387, 388, and 389) are undervalued. The commenter pointed out that legislation mandating Early Hearing Detection and Intervention (EHDI) has been passed in 35 States plus the District of Columbia. In these States, hearing screening must be performed prior to the newborn's discharge from the hospital unless prevented by medical complications. The cost per screening ranges from $15 to $30, which includes personnel, supplies, and equipment costs which are amortized over 3 years. The screening also includes costs for babies that require diagnostic evaluation.

The commenter requested that data from States that have not implemented EHDI programs be deleted from the Medicare supplemental database for, at a minimum, DRG 391 (Normal Newborn). The commenter stated that non-Medicare data used for developing the weights for the five newborn DRGs do not represent average costs if some of the 19 States that supply supplemental non-Medicare data are States that perform hearing screenings on less than 90 percent of newborns. The commenter further requested that we use data only from States that have EHDI programs that are operational at the 90 percent level. The commenter provided a list of States that meet these criteria.

Response: While we appreciate the commenter's furnishing us with information on the costs of providing services such as hearing screenings, it would be inappropriate for us to use this one service to determine whether or not to include a State's data because the State does not provide the service at a 90-percent level. The DRG weights are based on averages. As hospitals elect to include or exclude services, the weights will change over time. Therefore, we are not developing a criterion to exclude hospital data from States that do not have a 90-percent compliance level with EHDI.

Comment: One commenter noted that new procedure code 75.38, Fetal pulse osimetry, was classified as a nonoperative procedure code in Table 6B of the Addendum of the proposed rule. As a nonoperative procedure, it was not assigned to an MDC or to specific DRGs. The commenter requested that we assign code 75.38 to MDC 14 (Pregnancy, Childbirth and Puerperium), and the following DRGs:

DRG 370—(Caesarean Section with CC)
DRG 371—(Caesarean Section without CC)
DRG 372—(Vaginal Delivery with Complicating Diagnosis)
DRG 373—(Vaginal Delivery without CC)

The commenter believed it was critical that the clinical benefits and use of fetal pulse oximetry be closely tracked in order to monitor clinical outcomes and to recognize potential economic advantages. The commenter acknowledged that most labor and delivery patients are not Medicare beneficiaries. However, other third party payers benchmark hospital inpatient payment rates from Medicare DRGs. The commenter stated that if code 75.38 does not contribute or link to a DRG, it is often simply not coded. The commenter further stated that fetal oximetry is an exciting and significant emerging technology and that much knowledge can be gained by understanding its usage in the context of labor and delivery services.

Response: The commenter requested that 75.38 be assigned to the DRGs for deliveries (DRG 370 through 373). However, these DRGs are currently assigned based on the procedure codes for the specific type of delivery (caesarian or vaginal). Adding the procedure code 75.38 to these delivery DRGs would not affect the DRG assignment. The cases would still be assigned to the appropriate DRG based on the type of delivery, not whether the baby received fetal pulse oximetry. If the commenter is suggesting that the fetal pulse oximetry code, on its own, should lead to the DRG assignment, this option is not workable. Without knowing that the mother actually delivered, and the type of delivery, one would not be able to assign the case to one of the delivery DRGs. Once one knew through the procedure codes that the mother delivered, and the type of delivery, the addition of 75.38 would not add to the DRG assignment.

The commenter did not make an argument as to why 75.38 was incorrectly classified as a nonoperating room procedure. While we appreciate the commenter's desire that this new procedure code be used, assigning the code to existing DRGs is not consistent with the structure of DRGs. Procedure codes are only assigned to DRGs when they effect the DRG assignment logic. Therefore, we are not changing the operating room status of code 75.38, nor are we adding it to the delivery DRGs. Code 75.38 will be considered a nonoperative procedure.

c. Medicare Code Editor Changes

The Medicare Code Editor (MCE) is a front-end software program that detects and reports errors in the coding of claims data. The age conflict edit detects inconsistencies between a patient's age and any diagnosis on the patient's record. A subset of diagnoses is considered valid only for patients over the age of 14 years. These diagnoses are identified as ''adult'' diagnoses and range in age from 15 through 124 years. Therefore, any codes included on the Newborn Diagnoses edit are valid only for patients under age 14.

It has come to our attention that cases including the ICD–9–CM code 770.7, Chronic respiratory disease arising in the perinatal period, are being rejected. However, a condition such as bronchopulmonary dysplasia always originates in the perinatal period, so regardless of the patient's age, this condition is always coded as 770.7. The age at which the diagnosis was established or the age at continuing treatment does not affect the assignment of code 770.7.

Because correct coding is causing these claims to be rejected, in the May 4 proposed rule we proposed to remove code 770.7 from the Newborn Diagnoses edit in the MCE, as well as remove it from DRG 387 (Prematurity with Major Problems) and DRG 389 (Full Term Neonate with Major Problems). Clinical conditions in code 770.7, such as pulmonary fibrosis, would group to DRG 92 (Interstitial Lung Disease with CC) and DRG 93 (Interstitial Lung Disease without CC). Therefore, we proposed the addition of code 770.7 to DRGs 92 and 93, as they are most similar clinically. We indicated that we would monitor these cases in upcoming MedPAR data to ascertain that the cases consume similar resources.

We received no comments on these proposals, and are, therefore, adopting the change as final.

7. MDC 20 (Alcohol/Drug Use and Alcohol/Drug-Induced Organic Mental Disorders)

DRG 434 (Alcohol/Drug Abuse or Dependency, Detoxification or Other Symptomatic Treatment with CC) is assigned when the patient has a principal diagnosis of alcohol or drug abuse or dependence along with a secondary diagnosis classified as a CC. If these patients do not have a CC, they are assigned to DRG 435 (Alcohol/Drug Abuse or Dependency, detoxification or Other Symptomatic Treatment without CC). When the patients receive rehabilitation and detoxification therapy during the stay, they are assigned to DRG 437 (Alcohol/Drug Dependence, Combined Rehabilitation and Detoxification Therapy). If the patients receive only rehabilitation therapy, they are assigned to DRG 436 (Alcohol/Drug Dependence with Rehabilitation Therapy).

We have received inquiries as to why the relative weight for DRG 437, which includes both rehabilitation and detoxification (for FY 2001, the relative weight is .6606, with a geometric mean length of stay of 7.5) is lower than the FY 2001 relative weight for DRG 434, which includes only detoxification (.7256, with a geometric mean length of stay of 3.9). Likewise, the FY 2001 relative weight for DRG 436, which includes only rehabilitation (.7433), is higher than the FY 2001 relative weight for DRG 437, which includes combined rehabilitation and detoxification therapy (.6606). The inquirers indicated that those patients receiving the combination therapy would be expected to have a longer length of stay, require more services, and, therefore, be more costly to treat.

We analyzed data from the FY 2000 MedPAR file and did not find support for the inquirers' assertion that combination therapy is more costly to treat. The relative weights indicate that the presence of a CC in DRG 434 leads to a significantly higher weight than is found in DRG 435, which does not have a CC. Therefore, we analyzed the alcohol/drug DRGs and focused on eliminating the distinction between rehabilitation and rehabilitation with detoxification and assessing the impact of CCs. We combined data on DRGs 436 and 437 and then subdivided the data based on the presence or absence of a CC. The following table contains the results of the analysis.

AVERAGE CHARGES FOR CASES—WITH AND WITHOUT CCS

DRGS	With CC			Without CC		
	Count	Charge	Length of stay	Count	Charge	Length of stay
Detoxification Cases—DRG 434 and DRG 435	3,298	$8,548	5.0	9,689	$5,111	4.1
All Rehabilitation Cases—DRG 436 and DRG 437	3,298	8,117	10.1	4,473	7,407	9.6

We found that, for both the detoxification and rehabilitation DRGs, the with-CC group has higher charges than the without-CC group. However, the with-CC groups still contain the anomaly that the detoxification DRG 434 has a slightly higher average charge than the combined rehabilitation DRGs 436 and 437. It appears that any significant medical problems as indicated by the presence of a CC dominate the cost incurred by hospitals for treating alcohol and drug abuse patients. For the without-CC groups, the detoxification DRG 435 has substantially lower average charges than the combined rehabilitation DRGs 436 and 437. Because the average charges of the with-CC for both the detoxification DRG 434 and combined rehabilitation DRGs 436 and 437 have similar average charges, we proposed to combine these two groups.

Based on the results of our analysis, we proposed to restructure MDC 20 as follows. We first identified those cases with a principal diagnosis within MDC 20 where the patient left against medical advice. These cases are found in DRG 433 (Alcohol/Drug Abuse or Dependence, Left Against Medical Advice (AMA)). We next identified all remaining cases with a principal diagnosis within MDC 20 where there was a CC. We assigned these cases to a new DRG, (Alcohol/Drug Abuse or Dependence with CC). The remaining cases (without CC and did not leave against medical advice) were then divided into two new DRGs based on whether or not the patient received rehabilitation (Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation Therapy; and Alcohol/Drug Abuse or Dependence without CC, without Rehabilitation Therapy).

The following table illustrates the number of patients and average charges for each of the four proposed DRGs.

FREQUENCIES AND AVERAGE CHARGES FOR NEW DRGS

DRG	Group title	Number of cases	Average charges
433	Alcohol/Drug Abuse or Dependence, Left Against Medical Advice	3,509	$3,855
521	Alcohol/Drug Abuse or Dependence with CC	18,235	8,470
522	Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation Therapy	4,473	7,407
523	Alcohol/Drug Abuse or Dependence without CC, without Rehabilitation Therapy	9,689	5,111

This table illustrates that groups based first on the presence of CC and then on whether or not the patient receives rehabilitation therapy provide a much better explanation of differences in charges. Therefore, we proposed to retain DRG 433, make DRGs 434 through 437 invalid, and create new DRGs 521, 522, and 523 to include the diagnosis and procedure codes reflected in Chart 7 below.

CHART 7.—RESTRUCTURE OF MDC 20 (ALCOHOL/DRUG USE AND ALCOHOL/DRUG-INDUCED ORGANIC MENTAL DISORDERS)

Diagnosis and procedure code	Included in Existing DRG 433	Included in DRG 521	Included in DRG 522	Included in DRG 523
Principal diagnosis:				
All principal diagnosis within existing MDC 20 involving cases in which patients left against medical advice (AMA)	X			
All principal diagnoses within existing MDC 20 where there is a CC and where patient did not leave against medical advice (AMA)		X		
All principal diagnoses within existing MDC 20 without CC and where patient did not leave against medical advice (AMA).				
All principal diagnoses in existing MDC 20 without CC involving cases where patients did not leave against medical advice (AMA)				X
Procedure Codes:				
94.61 Alcohol rehabilitation			X	
94.63 Alcohol rehabilitation and detoxification			X	
94.64 Drug rehabilitation			X	
94.66 Drug rehabilitation and detoxification			X	
94.67 Combined alcohol and drug rehabilitation			X	
94.69 Combined alcohol and drug rehabilitation and detoxification			X	

Comment: One commenter was uncertain as to the intent of the reclassification of the DRGs to identify alcohol/drug use and alcohol/drug-induced organic mental disorders. The commenter expressed concern that the cases associated with alcohol/drug use would have a lower overall weight relative to the overall average weight of these cases in FY 2001. The commenter requested further information on the impact of this change in the final rule. Additionally, the commenter recommended that the title for DRG 521 be changed from ''Alcohol/Drug Abuse or Dependence with CC'' to ''Alcohol/Drug Abuse with CC, with or without Rehabilitation Therapy.''

Response: As described above, for FY 2001, cases receiving combined rehabilitation and detoxification (DRG 437) had a lower relative weight than patients receiving only detoxification (DRG 434) or rehabilitation (DRG 436). Since these relative weights are derived from actual claims data, we decided to review the issue to determine if other factors had any impact. It would be expected that those patients receiving the combination therapy would have a longer length of stay, require more services, and therefore be more costly to treat. This was not supported by the data.

The factor that seems to contribute the greatest to the costs of these cases is the presence of a CC. The presence of a CC had a greater impact on the average charges than did factors such as detoxification or rehabilitation. Once the importance of this factor was determined, the cases not leaving against medical advice (DRG 433) were split on whether or not a CC was present. Those with a CC were assigned to new DRG 521. The remaining cases were then split based on whether or not rehabilitation was provided.

As can be seen from the FY 2002 relative weights in the chart below, MDC 20 patients who have a CC are considerably more expensive to treat. They have the highest relative weight among this set of DRGs. The second highest weight is assigned to MDC 20 cases without CC who also received rehabilitation services.

DRG title	Number of of cases	Final weights
DRG 433 Alcohol/Drug Abuse or Dependence, Left AMA	5,522	.2888
DRG 521 Alcohol/Drug Abuse or Dependence with CC	28,014	.7355
DRG 522 Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation Therapy	6,852	.6249
DRG 523 Alcohol/Drug Abuse or Dependence without CC, without Rehabilitation Therapy	14,954	.3997

As can be seen from this chart, the majority of patients are assigned to DRG 521, which has the highest relative weight among the MDC 20 DRGs. As is the case for all DRGs, the relative weights reflect hospitals' actual charges submitted for bills in the FY 2000 MedPAR file. Data support the new splits based first on the presence of a CC and then on the presence of rehabilitation therapy. Therefore, we are adopting the proposed DRG classification changes as final without change.

While we appreciate the comment on modifying the title for DRG 521, we believe that it does not add to the clarity of the DRG. All MDC 20 patients who have not left AMA but who have a CC are assigned to DRG 521. The presence or absence of a code for rehabilitation therapy does not effect the DRG assignment for these cases. Therefore, we are adopting the proposed title as final without change.

8. MDC 25 (Human Immunodeficiency Virus Infections)

Effective October 1, 2000, ICD–9–CM diagnosis codes 783.2 (Abnormal loss of weight) and 783.4 (Lack of expected normal physiological development) were made invalid (65 FR 47171). These

two old diagnosis codes were expanded to five digits and the following new diagnosis codes were created:

783.21 Loss of weight
783.22 Underweight
783.40 Unspecified lack of normal physiological development
783.41 Failure to thrive
783.42 Delayed milestones
783.43 Short stature

These six revised codes were created in response to an industry request. Specifically, code 783.2 did not differentiate between whether the patient had lost weight recently or whether the patient was underweight. Code 783.4 was expanded to capture concepts such as failure to thrive, delayed milestones, and short stature. None of these concepts were captured in the old codes.

We listed these new codes in the August 1, 2000 final rule on the hospital inpatient prospective payment system in Table 6A—New Diagnosis Codes (65 FR 47169). At the time the final rule was published, all of these codes were assigned to DRGs 296 through 298. After the final rule was published, we received an inquiry as to why these new diagnosis codes were not included in MDC 25 as human immunodeficiency virus (HIV)-related conditions. The inquirer pointed out that the predecessor codes (783.2 and 783.4) were included in MDC 25 as HIV-related conditions and suggested that the new codes be added to MDC 25. These cases will be assigned to other MDCs if the patient does not have HIV.

In the proposed rule, we stated that we agreed that the expanded codes should have been placed in the MDC 25 as HIV-related conditions. The omission was an oversight. Therefore, we proposed to add diagnosis codes 783.21, 783.22, 783.40, 783.41, 783.42, and 783.43 as HIV-related conditions within MDC 25. When these six revised codes are reported with code 042 HIV, the patient will be classified within MDC 25.

Comment: One commenter supported the placement of codes 783.21, 783.22, 783.40, 783.41, 783.42, and 783.43, as HIV-related conditions within MDC 25.

Response: We appreciate the commenter's support and are adopting the proposed changes as final.

9. Surgical Hierarchies

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

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

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

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we proposed the modification of the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of the revised GROUPER software at the time the proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed in section II.C. of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed, because they will be based on more complete data. Consequently, in the proposed rule we stated that further revision of the hierarchy, using the above principles, might be necessary in the final rule.

In the May 4 proposed rule, we proposed to revise the surgical hierarchy for the pre-MDC DRGs, MDC 5 (Diseases and Disorders of the Circulatory System), MDC 8 (Diseases

and Disorders of the Musculoskeletal System & Connective Tissue) and MDC 20 (Alcohol/Drug Use & Alcohol/Drug Induced-Organic Mental Disorders) as follows:

- In the pre-MDC DRGs, we proposed to reorder Lung Transplant (DRG 495) above Bone Marrow Transplant (DRG 481). We also proposed to reorder Simultaneous Pancreas/Kidney Transplant (DRG 512) and Pancreas Transplant (DRG 513) above Lung Transplant (DRG 495).
- In MDC 5, we proposed to reorder Cardiac Defibrillator Implants (DRGs 514 and 515) above Other Cardiothoracic Procedures (DRG 108). We also proposed to reorder Percutaneous Cardiovascular Procedures (DRGs 516, 517, and 518) above Other Vascular Procedures (DRGs 478 and 479).
- In MDC 8, we proposed to reorder Cervical Spinal Fusion (DRGs 519 and 520) above Back & Neck Procedures Except Spinal Fusion (DRGs 499 and 500).
- In MDC 20, we proposed to order as follows: Alcohol/Drug Abuse or Dependence, Left AMA (DRG 433) above Alcohol/Drug Abuse or Dependence With CC (DRG 521); Alcohol/Drug Abuse or Dependence With CC (DRG 521) above Alcohol/Drug Abuse or Dependence With Rehabilitation Therapy Without CC (DRG 522); and Alcohol/Drug Abuse or Dependence With Rehabilitation Therapy Without CC (DRG 522) above Alcohol/Drug Abuse or Dependence Without Rehabilitation Therapy Without CC (DRG 523).

Comment: One commenter expressed support for hierarchy proposals.

Response: We appreciate the commenter's support. Based on a test of the proposed revisions using the March 2001 update of the FY 2000 MedPAR file and the revised GROUPER software, we have found that the revisions are still supported by the data, and no additional changes are indicated. Therefore, we are adopting these proposed changes as final.

10. Refinement of Complications and Comorbidities (CC) List

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

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

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions, and the August 1, 2000 final rule (65 FR 47064) for the FY 2001 revisions.) In the July 30, 1999 final rule (64 FR 41490) we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

In this final rule, we are making a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2001. (See section II.B.11. below, for a discussion of ICD–9–CM changes.) These changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 2001. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2001, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2001, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $133.00 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should

include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

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

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 18.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 19.0 of this manual, which includes the final FY 2002 DRG changes, will be available in October 2001 for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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

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

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

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

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

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

Our medical consultants identified those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under DRG 477 and, therefore, we did not propose to move any procedures from DRG 477 to one of the surgical DRGs. However, our medical consultants have identified a number of procedure codes that should be removed from DRG 468 and put into more clinically coherent DRGs. The movements of these codes are specified in the charts below:

MOVEMENT OF PROCEDURE CODES FROM DRG 468

Procedure code	Description	Included in DRG	Description
MDC 1—Diseases and Disorders of the Nervous System			
5495	Peritoneal Incision	7	Peripheral and Cranial Nerve and Other Nervous System Procedures with CC.
5495	Peritoneal Incision	8	Peripheral and Cranial Nerve and Other Nervous System Procedures without CC.
MDC 3—Diseases and Disorders of the Ear			
3821	Blood Vessel Biopsy	63	Other Ear, Nose, Mouth and Throat OR Procedure.
MDC 4—Diseases and Disorders of the Respiratory System			
3821	Blood Vessel Biopsy	76	Other Respiratory System OR Procedures with CC.

MOVEMENT OF PROCEDURE CODES FROM DRG 468—Continued

Procedure code	Description	Included in DRG	Description
3821	Blood Vessel Biopsy	77	Other Respiratory System OR Procedures with CC.
3929	Vascular Shunt & Bypass NEC	76	Other Respiratory System OR Procedures with CC.
3929	Vascular Shunt & Bypass NEC	77	Other Respiratory System OR Procedures with CC.
3931	Suture of Artery	76	Other Respiratory System OR Procedures with CC.
3931	Suture of Artery	77	Other Respiratory System OR Procedures with CC.
5411	Exploratory Laparotomy	76	Other Respiratory System OR Procedures with CC.
5411	Exploratory Laparotomy	77	Other Respiratory System OR Procedures with CC.
7749	Bone Biopsy NEC	76	Other Respiratory System OR Procedures with CC.
7749	Bone Biopsy NEC	77	Other Respiratory System OR Procedures with CC.
8669	Free Skin Graft NEC	76	Other Respiratory System OR Procedures with CC.
8669	Free Skin Graft NEC	77	Other Respiratory System OR Procedures with CC.
MDC 5—Diseases and Disorders of the Circulatory System			
3402	Exploratory Thoracotomy	120	Other Circulatory System OR Procedures.
3403	Reopen Thoractomy Site	120	Other Circulatory System OR Procedures.
3421	Transpleura Thoracoscopy	120	Other Circulatory System OR Procedures.
3422	Mediastinoscopy	120	Other Circulatory System OR Procedures.
3426	Open Mediastinal Biopsy	120	Other Circulatory System OR Procedures.
436	Distal Gastrectomy	120	Other Circulatory System OR Procedures.
437	Partial Gastrectomy with Jejunal Anastomosis	120	Other Circulatory System OR Procedures.
4389	Partial Gastrectomy	120	Other Circulatory System OR Procedures.
4399	Total Gastrectomy	120	Other Circulatory System OR Procedures.
4561	Multiple Segment Small Bowel Excision	120	Other Circulatory System OR Procedures.
4562	Partial Small Bowel Resection NEC	120	Other Circulatory System OR Procedures.
4572	Cecectomy	120	Other Circulatory System OR Procedures.
4573	Right Hemicolectomy	120	Other Circulatory System OR Procedures.
4574	Transverse Colon Resection	120	Other Circulatory System OR Procedures.
4575	Left Hemicolectomy	120	Other Circulatory System OR Procedures.
4579	Partial Large Bowel Excision NEC	120	Other Circulatory System OR Procedures.
458	Total Intra-Abdominal Colectomy	120	Other Circulatory System OR Procedures.
4593	Small-to-Large Bowel NEC	120	Other Circulatory System OR Procedures.
4603	Large Bowel Exteriorization	120	Other Circulatory System OR Procedures.
4613	Permanent Colostomy	120	Other Circulatory System OR Procedures.
4709	Other Appendectomy	120	Other Circulatory System OR Procedures.
4862	Anterior Rectal Resection With Colostomy	120	Other Circulatory System OR Procedures.
4863	Anterior Rectal Resection NEC	120	Other Circulatory System OR Procedures.
4869	Rectal Resection	120	Other Circulatory System OR Procedures.
5012	Open Liver Biopsy	120	Other Circulatory System OR Procedures.
540	Abdominal Wall Incision	120	Other Circulatory System OR Procedures.
MDC 6—Diseases and Disorders of the Digestive System			
5122	Cholecystectomy	170	Other Digestive System OR Procedures with CC.
5122	Cholecystectomy	171	Other Digestive System OR Procedures without CC.
5123	Laparoscopic Cholecystectomy	170	Other Digestive System OR Procedures with CC.
5132	GB-To-Intestine Anastomosis	170	Other Digestive System OR Procedures with CC.
5136	Choledochoenterostomy	170	Other Digestive System OR Procedures with CC.
5136	Choledochoenterostomy	171	Other Digestive System OR Procedures without CC.
5137	Hepatic Duct-GI Anastomosis	170	Other Digestive System OR Procedures with CC.
5137	Hepatic Duct-GI Anastomosis	171	Other Digestive System OR Procedures without CC.
5159	Bile Duct Incision NEC	170	Other Digestive System OR Procedures with CC.
5159	Bile Duct Incision NEC	171	Other Digestive System OR Procedures without CC.
MDC 7—Diseases and Disorders of the Hepatobiliary System and Pancreas			
540	Abdominal Wall Incision	201	Other Heptobiliary and Pancreas Procedure.
MDC 8—Diseases and Disorders of the Musculoskeletal System and Connective Tissue			
3479	Other Chest Wall Repair	233	Other Musculoskeletal System & Connective Tissue OR Procedure with CC.
3479	Other Chest Wall Repair	234	Other Musculoskeletal System & Connective Tissue OR Procedure with CC.
MDC 11—Diseases and Disorders of the Kideny and Urinary Tract			
540	Abdominal Wall Incision	315	Other Kidney & Urinary Tract OR Procedure.
5451	Laparoscopic Periton Adhesiolysis	315	Other Kidney & Urinary Tract OR Procedure.
5459	Other Periton Adhesiolysis	315	Other Kidney & Urinary Tract OR Procedure.

b. Reassignment of Procedures among DRGs 468, 476, and 477

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be moved from one of these DRGs to another of these DRGs based on average charges and length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If our medical consultants were to find these shifts, we would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we did not propose to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis Codes to MDCs

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

We received one comment in support of the proposed changes to the procedure codes in DRG 468, 476, and 477. In this final rule, we are adopting these proposed changes without further modification.

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

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

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

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

The Committee presented proposals for coding changes for implementation in FY 2002 at public meetings held on May 11, 2000 and November 17, 2000, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 08, 2001.

Copies of the Coordination and Maintenance Committee minutes of the 2000 meetings can be obtained from the CMS home page at: http://www.hcfa.gov/medicare/icd9cm.htm. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, MD 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; CMS, Center for Medicare Management, Purchasing Policy Group, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, MD 21244–1850. Comments may be sent by E-mail to: pbrooks@cms.hhs.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 2001. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section V. of the Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the proposed rule, we solicited comments only on the proposed DRG classification of these new codes.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2001. For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes). New procedure codes are shown in Table 6B. Table 6C contains invalid diagnosis codes, and Table 6D contains invalid procedure codes. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also include the DRG assignments for these revised codes. Revisions to procedure code titles are in Table 6F (Revised Procedure Codes Titles).

In September 2000, the Department implemented a policy of paying for inpatient hospital stays for Medicare beneficiaries participating in clinical trials (HCFA Program Memorandum AB 00–89, September 19, 2000). Hospitals were encouraged to identify the patients involved by reporting an ICD–9–CM code. This would allow the examination of data on the patients involved in clinical trials. However, there was no clear ICD–9–CM diagnosis code for patients who took part in a clinical trial. There was a code for patients receiving an examination as part of the control group for clinical trials. This control group code was V70.7 (Examination for normal comparison or control in clinical research). Hospitals were instructed to use V70.5 (Health examination of defined subpopulations), for patients participating in a clinical trial.

This coding directive has created some confusion because of the title and description of the two codes. Hospitals also have requested that all clinical patients be captured under one code. They indicated that the use of one code

would be especially useful because patients frequently do not know if they are part of the control group or are receiving new therapy.

To help alleviate the confusion, the ICD–9–CM Coordination and Maintenance Committee revised code V70.7. Effective October 1, 2001, the new title of code V70.7 is ''Examination of patient in clinical trial.'' This revision will make it easier to capture data on Medicare beneficiaries who are participating in a clinical trial.

Comment: One commenter questioned the DRG assignment of 525.12 (Loss of teeth due to periodontal disease) listed in Table 6A of the Addendum of the proposed rule. Table 6A in the proposed rule listed the proposed DRG assignments within MDC 3 for this new code as DRGs 182, 183, and 184. The commenter stated that the DRG assignments within MDC 3 should actually be DRGs 185, 186, and 187, since these were the DRGs used for its predecessor code, 525.1. The commenter also pointed out that the other new codes within this category (525.10–525.19) were assigned to DRGs 185, 186, and 187.

Response: The commenter is correct. We are assigning code 525.12 to DRGs 185, 186, and 187 within MDC 3. This is consistent with the way the other codes in the new category were assigned. In this final rule, we are correcting Table 6A to show that 525.12 is assigned to DRGs 185, 186, and 187 within MDC 3.

13. Other Issues

a. Pancreas Transplant

Effective July 1, 1999, Medicare covers whole organ pancreas transplantation if the transplantation is performed simultaneously with or after a kidney transplant (procedure codes 55.69 (Other kidney transplantation), or diagnosis code V42.0 (Organ or tissue replaced by transplant, Kidney), along with 52.80 (Pancreatic transplant, not otherwise specified), or 52.82 (Homotransplant of pancreas)). A discussion of the history of these coverage decisions and codes can be found in the August 1, 2000 final rule on the prospective payment system for FY 2001 (65 FR 47067).

We discussed the appropriate DRG classification for these cases in both the July 30, 1999 final rule (64 FR 41497) and the August 1, 2000 final rule (65 FR 47067). Currently, cases can be assigned to one of two major DRGs depending on principal diagnosis. If a kidney transplant and a pancreas transplant are performed simultaneously on a patient with chronic renal failure secondary to diabetes with renal manifestations (diagnosis codes 250.40 through 250.43), the cases will be assigned to DRG 302 (Kidney Transplant). If a pancreas transplant is performed following a kidney transplant (during a different hospital admission) on a patient with chronic renal failure secondary to diabetes with renal manifestations, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This is because pancreas transplant is not assigned to MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract), the MDC to which a principal diagnosis of chronic renal failure secondary to diabetes is assigned.

In the August 1, 2000 final rule, we noted that we would continue to monitor these transplant cases to determine the appropriateness of establishing a new DRG. For the May 4 proposed rule, using data in the FY 2000 MedPAR file (updated through May 31, 2000), we analyzed the cases for which procedure codes 52.80 and 52.82 were reported. (Our data showed that 15 of the cases were coded using 52.83 (Heterotransplant of pancreas), which is not a covered procedure under any circumstances.) We identified a total of 221 cases for this time period. The United Network for Organ Sharing (UNOS) reported it had identified 270 cases through September 2000.

These 221 MedPAR cases were distributed over 6 DRGs, with the majority (158 cases or 72 percent) assigned to DRG 302, and 23 cases (10 percent) assigned to DRG 468. The remaining 40 cases were distributed between 4 other DRGs, with the majority (25 cases) being assigned to DRG 292 (Other Endocrine, Nutritional and Metabolic OR Procedures with CC). Four cases were assigned to DRG 483 (Tracheostomy with Principal Diagnosis except Face, Mouth and Neck Diagnoses) in the Pre-MDC grouping, which took precedence over any other DRG assignment.

We arrayed the data based on the presence or absence of kidney transplant; that is, pancreas transplant codes with or without 55.69. The majority of cases (166 or 75 percent) had the combined kidney-pancreas transplant in one operative episode, with 55 (25 percent) of the cases having pancreas transplant subsequent to the kidney transplant. Differences in hospital charges were significantly higher for a pancreas transplant plus a kidney transplant ($138,809) than a pancreas transplant alone ($85,972), and both were higher than average standardized charges in DRG 302 ($64,760) or DRG 468 ($39,707), although it must be noted that these figures do reflect the resource intensive patients assigned to DRG 483. Those patients in DRG 483 had average standardized charges of $377,934.

Because these categories of patients do not fit into existing DRGs from either a clinical or resource perspective, in the May 4 proposed rule, we proposed to create two new DRGs that would reflect these patients' unique clinical profiles: DRG 512 (Simultaneous Pancreas/Kidney Transplant) and DRG 513 (Pancreas Transplants). Cases grouped to either DRGs 512 or 513 must have a principal or secondary diagnosis code and procedure code or combination of procedure codes as indicated in the chart below:

COMPOSITION OF PROPOSED DRGS 512 AND 513

Diagnosis and procedure codes	Included in DRG 512	Included in DRG 513
Principal or Secondary ICD–9–CM Diabetes Mellitus Code:		
250.00 Diabetes mellitus without mention of complication, Type II or unspecified type, not as stated as uncontrolled	X	X
250.01 Diabetes mellitus without mention of complication, Type I, not stated as uncontrolled	X	X
250.02 Diabetes mellitus without mention of complication, Type II or unspecified type, uncontrolled	X	X
250.03 Diabetes mellitus without mention of complication, Type I, uncontrolled	X	X
250.10 Diabetes with ketoacidosis, Type II or Unspecified type, not stated as uncontrolled	X	X
250.11 Diabetes with ketoacidosis, Type I, not stated as uncontrolled	X	X
250.12 Diabetes with ketoacidosis, Type II or unspecified type, uncontrolled	X	X
250.13 Diabetes with ketoacidosis, Type I, controlled	X	X
250.20 Diabetes with hyperosmolarity, Type II or unspecified type, not stated as uncontrolled	X	X
250.21 Diabetes with hyperosmolarity, Type I, not stated as uncontrolled	X	X

COMPOSITION OF PROPOSED DRGS 512 AND 513—Continued

Diagnosis and procedure codes	Included in DRG 512	Included in DRG 513
250.22 Diabetes with hyperosmolarity, Type II or unspecified type, uncontrolled	X	X
250.23 Diabetes with hyperosmolarity, Type I, uncontrolled	X	X
250.30 Diabetes with other coma, Type II or unspecified type, not stated as uncontrolled	X	X
250.31 Diabetes with other coma, Type I, not stated as uncontrolled	X	X
250.32 Diabetes with other coma, Type II or unspecified type, uncontrolled	X	X
250.33 Diabetes with other coma, Type I, uncontrolled	X	X
250.40 Diabetes with renal manifestations, Type II or unspecified type, not stated as uncontrolled	X	X
250.41 Diabetes with renal manifestations, Type I, not stated as uncontrolled	X	X
250.42 Diabetes with renal manifestations, Type II or unspecified type, uncontrolled	X	X
250.43 Diabetes with renal manifestations, Type I, uncontrolled	X	X
250.50 Diabetes with ophthalmic manifestations, Type II or unspecified type, not stated as uncontrolled	X	X
250.51 Diabetes with ophthalmic manifestations, Type I, not stated as uncontrolled	X	X
250.52 Diabetes with ophthalmic manifestations, Type II or unspecified type, uncontrolled	X	X
250.53 Diabetes with ophthalmic manifestations, Type I, uncontrolled	X	X
250.60 Diabetes with neurological manifestations, Type II or unspecified type, not stated as uncontrolled	X	X
250.61 Diabetes with neurological manifestations, Type I, not stated as uncontrolled	X	X
250.62 Diabetes with neurological manifestations, Type II or unspecified type, uncontrolled	X	X
250.63 Diabetes with neurological manifestations, Type I uncontrolled	X	X
250.70 Diabetes with peripheral circulatory disorders, Type II or unspecified type, not stated as uncontrolled	X	X
250.71 Diabetes with peripheral circulatory disorders, Type I, not stated as uncontrolled	X	X
250.72 Diabetes with peripheral circulatory disorders, Type II or unspecified type, uncontrolled	X	X
250.73 Diabetes with peripheral circulatory disorders, Type I, uncontrolled	X	X
250.80 Diabetes with other specified manifestations, Type II or unspecified type, not stated as uncontrolled	X	X
250.81 Diabetes with other specified manifestations, Type I, not states as uncontrolled	X	X
250.82 Diabetes with other specified manifestations, Type II or unspecified type, uncontrolled	X	X
250.83 Diabetes with other specified manifestations, Type I, uncontrolled	X	X
250.90 Diabetes with unspecified complication, Type II or unspecified type, not states as uncontrolled	X	X
250.91 Diabetes with unspecified complication, Type I, not stated as uncontrolled	X	X
250.92 Diabetes with unspecified complication, Type II or unspecified type, uncontrolled	X	X
250.93 Diabetes with unspecified complication, Type I, uncontrolled	X	X
Principal or Secondary Diagnosis Code:		
585 Chronic renal failure.	X	X
403.01 Hypertensive renal disease, malignant, with renal failure	X	X
403.11 Hypertensive renal disease, benign, with renal failure	X	X
403.91 Hypertensive renal disease, unspecified, with renal failure	X	X
404.02 Hypertensive heart & renal disease, malignant, with renal failure	X	X
404.03 Hypertensive heart & renal disease, malignant, with congestive heart failure and renal disease	X	X
404.12 Hypertensive heart & renal disease, benign, with renal failure	X	X
404.13 Hypertensive heart & renal disease, benign, with congestive heart failure and renal disease	X	X
404.92 Hypertensive heart & renal disease, unspecified, with renal failure	X	X
404.93 Hypertensive heart & renal disease, unspecified, with congestive heart failure and renal failure	X	X
V42.0 Organ or tissue replaced by transplant, kidney	X	X
V43.89 Organ or tissue replaced by other means, other (Kidney)	X	X
Procedure Code:		
52.80 Pancreatic transplant, not otherwise specified	.....	X
52.82 Homotransplant of pancreas	.....	X
Combination Procedure Codes:		
52.80 Pancreatic transplant, not otherwise specified, **Plus** 55.69 Other kidney transplantation	X	.....
Or 52.82 Homotransplant of pancreas **Plus** 55.69 Other kidney transplantation	X	.....

The logic for the DRG 512 accepts the pair of diagnosis codes in any position (principal/secondary or secondary/secondary). The pair of procedure codes must be present along with the two diagnosis codes. This DRG will be placed in the Pre-MDC GROUPER logic immediately following DRG 480 (Liver Transplant).

The logic for DRG 513 accepts the pair of diagnosis codes in any position (principal/secondary or secondary/secondary). Only one procedure code must be used along with the two diagnosis codes. This DRG will be placed in the Pre-MDC GROUPER logic immediately following new DRG 512 (Simultaneous Pancreas/Kidney Transplant).

We received two comments on this proposal. One commenter supported the creation of the two new DRGs; a summary of the other comment follows:

Comment: One commenter noted that, as pancreas transplants were approved by Medicare on July 1, 1999, a special billing procedure should be made available to hospitals to enable hospitals to bill for the transplant DRG back to the effective date of the covered service.

Response: DRGs 512 and 513 are effective for discharges occurring on or

after October 1, 2001, for FY 2002. Discharges involving pancreas transplants occurring prior to that time are assigned to existing DRGs as described above. Therefore, there is no need for hospitals to resubmit their bills.

We are adopting the establishment of proposed DRGs 512 and 513 as final.

b. Intestinal Transplantation

Effective April 1, 2001, Medicare covers intestinal transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure (Medicare Program Memorandum Transmittal No. AB–01–58, April 12, 2001). This procedure is covered only when performed for patients who have failed total parenteral nutrition (TPN) and only when performed in centers that meet approval criteria.

Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity.

If an intestinal transplantation alone is performed on a patient with an intestinal principal diagnosis, the case would be assigned to either DRG 148 (Major Small & Large Bowel Procedures With CC) or DRG 149 (Major Small & Large Bowel Procedures Without CC). If an intestinal transplantation and a liver transplantation are performed simultaneously, the case would be assigned to DRG 480 (Liver Transplant).

If an intestinal transplantation alone is performed on a patient with an intestinal principal diagnosis, the case would be assigned to either DRG 148 (Major Small & Large Bowel Procedures with CC) or DRG 149 (Major Small & Large Bowel Procedures Without CC). If an intestinal transplantation and a liver transplantation are performed simultaneously, the case would be assigned to DRG 480 (Liver Transplant).

If an intestinal transplantation and a pancreas transplantation are performed simultaneously, currently the case would be assigned to either DRG 148 or DRG 149. Effective October 1, 2001, the case would be assigned to DRG 513 (Pancreas Transplant). We proposed to make a conforming change to the regulations at § 412.2(e)(4) and § 486.302 to include intestines (and multivisceral organs) in the list of organs for which Medicare pays for the acquisition costs on a reasonable cost basis.

Effective October 1, 2000, procedure code 46.97 (Transplant of intestine) was created. For the proposed rule, we examined our Medicare claims data to determine whether it was appropriate to propose a new intestinal transplant DRG. We examined data in the FY 2000 MedPAR file containing bills submitted through May 31, 2000. Because procedure code 46.97 was not in place during this time we focused our examination on the previous code assignment for intestinal transplant, code 46.99 (Other operations on intestines), and facilities that are currently performing intestinal transplantation. We were able to identify only one case, with an average charge of approximately $10,738 as compared to the average standardized charges for DRGs 148 and 149, which are approximately $37,961, and $16,965, respectively. We will continue to monitor these cases to determine whether it may be appropriate in the future to establish a new DRG.

Comment: One commenter recommended performing data analysis next year to determine if a separate intestinal transplantation DRG should be created based on the fact that these procedures are being performed on a more frequent basis. Another commenter suggested that the preamble specifically state that while the acquisition costs for heart, liver, lung, and pancreas transplants continue to be paid on a reasonable cost basis, the acquisition costs for intestinal transplantation will be paid through the hospital inpatient prospective payment system DRG payment mechanism.

Response: It is our intent to continue to monitor these cases to determine whether it may be appropriate in the future to establish a new DRG.

To clarify the issue of acquisition costs, Medicare Program Memorandum Transmittal No. AB–01–58, released April 12, 2001, states that Medicare will not pay transplant facilities on a reasonable cost basis for organ acquisition for intestinal or multivisceral transplants. The DRG payment will be payment in full for hospital services related to this procedure. However, in this final rule, we are implementing a conforming change to the regulations at § 412.2(e)(4) and § 486.302, to include intestines (and multivisceral organs) in the list of organs for which Medicare pays for the acquisition costs on a reasonable cost basis. This change is effective with acquisition costs incurred on or after October 1, 2001. After that date, costs associated with the acquisition of intestines and multivisceral organs will be paid on a reasonable cost basis. Costs associated with intestines procured separately will be allocated to an intestine cost center and allocated on Worksheet D–6. Multivisceral organ transplantation includes organs in the digestive system (that is, stomach, duodenum, pancreas, liver, intestine, and colon). Multivisceral procurements, including an organ(s) as defined at § 486.302 as well as the intestine (small bowel), will be allocated to the intestinal acquisition cost center. Multivisceral procurements are procured en bloc and the entire cost of procuring all of the organs will be allocated to the intestinal acquisition cost center.

c. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

Comment: Although this issue was not addressed in the proposed rule, we received one comment requesting that the add-on payment for blood clotting factors administered to hemophilia inpatients include adequate reimbursement for hospitals that treat beneficiaries with acquired hemophilia.

Response: According to section 4452 of Public Law 105–33, which amended section 6011(d) of Public Law 101–239, prospective payment hospitals receive an additional payment for costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients.

Hemophilia, a bleeding disorder characterized by prolonged clotting time, is caused by a deficiency of a factor necessary for blood to clot. In the August 29, 1997 final rule implementing section 4452 of Public Law 105–33 (62 FR 46002), we stated that hemophilia was considered to encompass the following conditions: Factor VIII deficiency (classical hemophilia); Factor IX deficiency (also termed plasma thromboplastin component (PTC) or Christmas factor deficiency); and Von Willebrand's disease. The most common factors required by hemophiliacs to increase coagulation are Factor VIII and Factor IX; a small number of hemophiliacs have developed inhibitors to these factors and require special treatment. We did not receive any comments regarding this coverage until, most recently, the cases of acquired hemophilia, which affects a small subset of individuals (1 in 1 million), were brought to our attention.

We are revising our claims processing instructions to permit add-on payments for the following ICD–9–CM diagnosis codes associated with acquired hemophilia:

286.5 Hemorrhagic disorder due to circulating anticoagulants

286.7 Acquired coagulation factor deficiency.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 2002 recalibration as we did for FY 2001 (August 1, 2000 final rule (65 FR 47069)). That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 2000 MedPAR file. (For the FY 2001 recalibration, we used the FY 1999 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 2000 MedPAR data (discharges occurring between October 1, 1999 and September 30, 2000), based on bills received by CMS through March 31, 2001, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 2000 MedPAR file includes data for approximately 11,094,323 Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 2000 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions discussed in section II.B. of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG are eliminated.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1999 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, lung, and pancreas transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs: DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); DRG 480 (Liver Transplant); DRG 495 (Lung Transplant); and proposed new DRGs 512 (Simultaneous Pancreas/Kidney Transplant) and 513 (Pancreas Transplant). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We use that same case threshold in recalibrating the DRG weights for FY 2002. Using the FY 2000 MedPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weights for these 37 low-volume DRGs by adjusting the FY 2001 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The new weights are normalized by an adjustment factor (1.44556) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system, and accounts for the gradual shift in cases toward higher-weighted DRGs over time.

We received no comments on DRG recalibration.

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

III. Changes to the Hospital Wage Index

A. Background

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

We note that, effective April 1, 1990, the term Metropolitan Area (MA) replaced the term MSA (which had been used since June 30, 1983) to describe the set of metropolitan areas consisting of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in

the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

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

B. FY 2002 Wage Index Update

The FY 2002 wage index values in section V of the Addendum to this final rule (effective for hospital discharges occurring on or after October 1, 2001 and before October 1, 2002) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1998 (the FY 2001 wage index was based on FY 1997 wage data).

The final FY 2002 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 2001 wage index:

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

Consistent with the wage index methodology for FY 2001, the wage index for FY 2002 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system such as skilled nursing facility (SNF) services, home health services, or other subprovider components that are not subject to the prospective payment system.

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

C. FY 2002 Wage Index

Because the hospital wage index is used to adjust payments to hospitals under the prospective payment system, the wage index should, to the extent possible, reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. In response to concerns within the hospital community related to the removal, from the wage index calculation, of costs related to graduate medical education (GME) (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), which are paid by Medicare separately from the prospective payment system, the AHA convened a workgroup to develop a consensus recommendation on this issue. The workgroup recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase-out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000. In keeping with the decision to phase-out costs related to GME and CRNAs, the final FY 2002 wage index is based on a blend of 40 percent of an average hourly wage including these costs, and 60 percent of an average hourly wage excluding these costs.

Beginning with the FY 1998 cost reports, we revised the Worksheet S–3, Part II so that hospitals can separately report teaching physician Part A costs on lines 4.01, 10.01, 12.01, and 18.01. Therefore, it is no longer necessary for us to conduct the special survey we used for the FY 2000 and FY 2001 wage indexes (64 FR 41505 and 65 FR 47071).

1. Health Insurance and Health-Related Costs

In the August 1, 2000 final rule, we clarified our definition of ''purchased health insurance costs'' and ''self-insurance'' for hospitals that provide health insurance to employees (65 FR 47073). For purposes of the wage index, purchased or self-funded health insurance plan costs include the hospitals' insurance premium costs, external administration costs, and the share of costs for services delivered to employees.

In response to a comment received concerning this issue, we stated that, for self-funded health insurance costs, personnel costs associated with hospital staff that deliver the services to the employees must continue to be excluded from wage-related costs if the costs are already included in the wage data as salaries on Worksheet S–3, Part II, Line 1. However, after further consideration of this policy, particularly with respect to concerns expressed by our fiscal intermediaries about the level of effort required during the wage index desk review process to ensure hospitals are appropriately identifying and excluding these costs, in the May 4, 2001 proposed rule we proposed a revision. Effective with the calculation of the FY 2003 wage index, for either purchased or self-funded health insurance, we proposed to allow personnel costs associated with hospital staff who deliver services to employees to be included as part of the wage-related costs. We believe the proposed revised policy will ensure that health insurance costs are consistently reported by hospitals. Health insurance costs would continue to be developed using generally accepted accounting principles.

In the August 1, 2000 final rule (65 FR 47073), we further clarified that health-related costs (including employee physical examinations, flu shots, and clinic visits, and other services that are not covered by employees' health insurance plans but are provided at no cost or at discounted rates to employees of the hospital) may be included as ''other'' wage-related costs if, among other criteria, the combined cost of all such health-related costs is greater than one percent of the hospital's total salaries (less excluded area salaries).

For purposes of calculating the FY 2003 wage index (which will be based on data for cost reporting periods beginning in FY 1999), we proposed to revise this policy to allow hospitals to include health-related costs as allowable core wage-related costs.

Comment: One commenter supported our proposal to include health-related costs as core wage-related costs. The commenter also agreed with our proposal to include all personnel costs associated with hospital staff who deliver health services to employees. However, the commenter expressed concern that the proposed changes would require burdensome and duplicative revisions to cost reports that have already been filed.

Response: We believe that these revised policies (to eliminate the

distinction between purchased health insurance and self-funded health insurance, and to treat costs associated with health-related services that are not part of the employees' health insurance plan consistent with costs included in the plan) will ensure that these costs are treated consistently across hospitals and fiscal intermediaries.

In response to the commenter's concern that the policy will require revisions to previously submitted cost reports, we believe the changes are not significant, particularly in light of the volume of changes submitted every year by hospitals during the wage data review process (see discussion in section III.G. of this final rule). The cost report changes necessary to implement these policy changes involve including costs previously disallowed. In the case of personnel costs associated with hospital staff who deliver services to employees, these costs would have already been identified in order to be excluded from the wage data. With respect to health services provided outside the employees' health insurance plan, we acknowledge that some hospitals may not have tracked these costs because they did not qualify for inclusion as other wage-related costs. However, due to concerns expressed by fiscal intermediaries about the difficulty of identifying these costs separate from those that are part of the insurance plan, we believe there may be inconsistencies in the current data with regard to how these costs are treated. Therefore, we believe, in the interest of improving the consistency of the data, that we should begin to allow these costs as core wage-related costs effective with the FY 2003 wage index.

2. Costs of Contracted Pharmacy and Laboratory Services

Our policy concerning inclusion of contract labor costs for purposes of calculating the wage index has evolved over the years. We recognize the role of contract labor in meeting special personnel needs of many hospitals. In addition, improvements in the wage data have allowed us to more accurately identify contract labor costs and hours. As a result, effective with the FY 1994 wage index, we included the costs of direct patient care contract services in the wage index calculation. The FY 1999 wage index included the costs and hours of certain management contract services, and the FY 2000 wage index included the costs for contract physician Part A services. (The 1996 proposed rule (61 FR 27456) provided an in-depth background to the issues related to the inclusion of contract labor costs in the wage index calculation.)

We revised the 1998 cost report to collect the data associated with contract pharmacy, Worksheet S–3, Part II, Line 9.01, and contract laboratory, Worksheet S–3, Part II, Line 9.02. The cost reporting instructions for these line numbers followed that for all contract labor lines; that is, to include the amount paid for services furnished under contract for direct patient care, and not include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (Medicare Provider Reimbursement Manual, Part 2, Cost Reporting Forms and Instructions, Chapter 36, Transmittal 6, pages 36–32). Effective with the FY 2002 wage index, which uses FY 1998 wage data, we are including in this final rule (as proposed in the May 4 proposed rule) the costs and hours of contract pharmacy and laboratory services.

Comment: Two commenters supported our proposed policy to include the costs and hours of contract pharmacy and laboratory as direct patient care contract labor in the FY 2002 wage index. However, both commenters recommended that clearer guidelines be provided to ensure consistency in interpretation by fiscal intermediaries and contract vendors.

Response: Beginning with the FY 2002 wage index, we are including the costs and hours of contract pharmacy and laboratory services in the calculation of the wage index. Further instructions for reporting contract pharmacy and laboratory costs will be included in Transmittal 8 of the cost report, due for release in early fall 2001.

3. Collection of Occupational Mix Data

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require that the Secretary must provide for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The initial collection of these data must be completed by September 30, 2003, for application beginning October 1, 2004.

Currently, the wage data collected on the cost report reflect the sum of wages, hours, and wage-related costs for all hospital employees. There is no separate collection by occupational categories of employees, such as registered nurses or physical therapists. Total salaries and hours reflect management decisions made by hospitals in terms of how many employees within a certain occupation to employ to treat different types of patients. For example, a large academic medical center may tend to hire more high-cost specialized employees to treat its more acutely ill patient population. The argument is that the higher labor costs incurred to treat this patient population are reflected in the higher case mix of these hospitals, and therefore, reflecting these costs in the wage index is essentially counting them twice.

An occupational mix adjustment can be used to account for hospital management decisions about how many employees to hire in each occupational category. Occupational mix data measure the price the hospital must pay for employees within each category. A wage index that reflected only these market prices would remove the impact of management decisions about the mix of employees needed and, therefore, better capture geographic variations in the labor market.

We have examined this issue previously. In the May 27, 1994 **Federal Register** (59 FR 27724), we discussed the outcome of consideration of this issue by a hospital workgroup. At that time, the workgroup's consensus was that the data required to implement an occupational mix adjustment were not available and the likelihood of obtaining such data would be minimal. There seemed to be little support among hospital industry representatives for developing a system that would create additional reporting burdens with an unproven or minimal impact on the distribution of payments. Also, in the August 30, 1991 **Federal Register** (56 FR 43219), we stated our belief that the collection of these data would be costly and difficult.

In considering the format to collect occupational mix data, we looked to data currently being collected by the Bureau of Labor Statistics (BLS), which conducts an annual mail survey to produce estimates of employment and wages for specific occupations. This program, Occupational Employment Statistics (OES), collects data on wage and salary workers in nonfarm establishments in order to produce employment and wage estimates for over 700 occupations.

The OES survey collects wage data in 12 hourly rate intervals. Employers report the number of employees in an occupation per each wage range. To illustrate, the wage intervals used for the 1999 survey are as follows:

Interval	Hourly wages	Annual wages
Range A	Under $6.75	Under $14,040.
Range B	$6.75 to $8.49	$14,040 to $17,659.
Range C	8.50 to 10.74	17,660 to 22,359.
Range D	10.75 to 13.49	22,360 to 28,079.
Range E	13.50 to 16.99	28,080 to 35,359.
Range F	17.00 to 21.49	35,360 to 44,719.
Range G	21.50 to 27.24	44,720 to 56,679.
Range H	27.25 to 34.49	56,680 to 71,759.
Range I	34.50 to 43.74	71,760 to 90,999.
Range J	43.75 to 55.49	91,000 to 115,439.
Range K	55.50 to 69.99	115,440 to 145,599.
Range L	70.00 and over	145,600 and over.

We noted that this table is for illustrative purposes, and that we may update the data ranges in our actual collection instrument.

Although we initially considered using the OES data, section 304(c) of Public Law 106–554 requires us to collect data from every short-term, acute care hospital. The OES data are a sample survey and, therefore, as currently conducted, are not consistent with the statutory requirement to include data from every hospital. Another issue with using OES data is that, for purposes of the Medicare wage index, the hospitals' data must be reviewed and verified by the fiscal intermediaries. The OES survey is a voluntary survey for most States.

Although we decided to pursue a separate data collection effort than OES, we proposed in the May 4, 2001 proposed rule to model our format after the one used by OES. In this way, hospitals participating in the OES survey would have no additional recordkeeping and reporting requirements beyond those of the OES survey.

The OES survey of the hospital industry is designed to capture all occupational categories within the industry. For purposes of adjusting the wage index for occupational mix, we do not believe it is necessary to collect data from such a comprehensive scope of categories. Furthermore, because the data must be audited, a comprehensive list of categories would be excessively burdensome.

In deciding which occupational categories to include, we reviewed the occupational categories collected by OES and identified those with at least 35,000 hospital employees. Our goal is to collect data from a sample of occupational categories that provides a valid measure of wage rates within a geographical area. In the May 4 proposed rule, using this threshold of at least 35,000 employees within a category nationally, we proposed to collect data on the number of employees by wage range as illustrated in the above table, for the occupational categories listed below. The following data, which was also listed in the proposed rule, are based on the 1998 OES survey. (These data are no longer available on the internet.)

OES code	Category	Number of employees	Percent of total hospital employees	Mean hourly wage
15008	Medicine and Health Services Manager	93,680	1.9	$27.38
27302	Social Workers, Medical and Psychiatric	53,360	1.1	16.33
32102	Physicians and Surgeons	125,640	2.6	43.76
32308	Physical Therapists	39,840	0.8	26.14
32502	Registered Nurses	1,231,980	25.0	21.12
32505	Licensed Practical Nurses	206,360	4.2	13.39
32517	Pharmacists	46,860	1.0	28.62
32911, 32928, and 32931	Clinical Technologists and Technicians	122,380	2.50	11.69
51002, 55105, 55108, 55305, 55332, and 55347.	First-Line Supervisors and Clerical Workers	445,730	9.5	11.39
65038, 67002, and 67005	Food Preparation Workers and Housekeeping	218,440	4.5	8.17
66008	Nursing Aides, Orderlies, and Attendants	301,240	6.2	8.67

We proposed that this list of occupational categories provides a good representation of the employee mix at most hospitals. It has since come to our attention that the occupational categories listed in the proposed rule have been replaced by Standard Occupational Category definitions.

Because we had not yet settled on the methodology to use the occupational mix data in the wage index, we discussed in the proposed rule one option to weight each hospital's wage index by its occupational mix index. This requires calculating a national occupational mix index and then breaking it down by MSA and by hospital, similar to how the wage index is broken down. In this way, the wage index would capture geographic differences in wage rates. The decision about how to apply the occupational mix index to the wage index depends on the quality of the data collected, since this effort will be the first time wage and hour data by occupation are collected in this audited manner.

Section 304(c) directs the Secretary to provide for the collection of these data by September 30, 2003, and to apply them in the wage index by October 1, 2004. Therefore, the data are to be incorporated in the FY 2005 wage index. Under our current timetable, the FY 2005 wage index will be based on wage data collected from hospitals' cost reporting periods beginning during FY 2001. In order to facilitate the fiscal intermediaries' review of these data, we believe the occupational mix data should coincide with the data otherwise

used to calculate the cost report. Therefore, we will conduct a special survey of all short-term acute-care hospitals that are required to report wage data to collect these data coinciding with hospitals' FY 2001 cost reports.

Comment: Several commenters expressed interest in working with us to develop an appropriate data collection tool. They suggested that the data be relatively simple for hospitals to gather and submit, and should be collected on 100 percent of hospital employees. Another commenter recommended that, at least initially, only data on nursing categories would be sufficient since nurses are 35 percent of hospital employees and can be divided into a few easily distinguishable categories. Two commenters offered examples for how these data are collected in their area. Some commenters wanted these data incorporated in the cost report to limit the number of forms hospitals must complete and to improve the response rate.

Response: We agree that it would be beneficial to work with the industry to develop a workable data collection tool, especially given the importance of the wage index in adjusting hospital payments. We appreciate the comments on the option presented in the proposed rule and believe that these comments will help initiate further thought toward the development of an occupational mix survey that can be administered without excessive burden on hospitals, the fiscal intermediaries, or CMS.

Due to time constraints in meeting the statutory deadlines, our intention at this point is to attempt to develop a survey instrument for the initial collection of occupational mix data that can be used by hospitals during calendar year 2002. Therefore, prior to January 1, 2002, we plan to work with the hospital community to develop a survey instrument. We believe issues related to the sample size of the data collected and the appropriate occupational categories to collect can best be resolved through consultation with the industry. Therefore, we will be contacting those organizations that expressed an interest in consultation in their comments. Other interested parties are encouraged to contact us as well.

After developing a method that appropriately balances the need to collect accurate and reliable data with the need to collect data hospitals can be reasonably expected to have available, we will issue instructions as to the type of data to be collected, in advance of actually requiring hospitals to begin providing the data.

Comment: Some commenters asked us to further develop the planned use of the occupation information and then decide what information is required. They requested that we publish the projected economic effects of an occupational mix adjustment upon each hospital as soon as feasible, and demonstrate tangible benefits prior to requiring hospitals to collect data. One commenter offered a specific methodology that could be employed. Other commenters want the methodology phased-in over time to allow hospitals time to adjust to different payment levels.

Response: In the proposed rule, we stated that we had not yet settled on the actual methodology for using the occupational mix data in the calculation of the wage index. We indicated the decision as to how the data will be used is dependent on the quality of the data collected. That is still the case. Furthermore, as discussed above, we intend to develop an appropriate data collection instrument in consultation with the hospital community. Therefore, until decisions are made with regard to the specific data to be collected, we cannot specify how the data will be used. However, the selection of an appropriate methodology (including a possible phase-in) will be influenced by analysis of the impacts of the method on hospital payments.

Comment: Two commenters expressed concerns that adopting the occupational mix adjustment for the wage index will lower the average hourly wage of teaching hospitals because of their mix of highly skilled, higher paid employees to treat patients with more complex conditions. These commenters argued that implementation of the occupational mix adjustment should proceed only in conjunction with the adoption of severity-adjusted DRGs. These commenters wrote that the current DRG system does not adequately recognize patient severity and pay for the higher resource costs associated with complex patients, but teaching hospitals can recoup some of these losses because their higher employee skill mix is reflected in their average hourly wage.

Furthermore, one commenter countered the argument that the higher labor costs incurred to treat a more severely ill patient population are reflected in the higher case mix of these hospitals and, therefore, reflecting these costs in the wage index is essentially counting them twice. This commenter pointed out that, because the DRG weights are based on hospital charges that are standardized by, among other factors, the area wage index, the weights of tertiary care DRGs are lower than they would be if the average charge per case were not first standardized by the wage index. However, the commenter went on to state that it is preferable to account for skill mix in the wage index rather than the case-mix index.

Response: As we stated in the August 1, 2000 final rule (65 FR 47103), we agree that severity-adjusted DRGs have potential for reducing discrepancies between payments and costs for individual cases (60 FR 29246). We have stated that, prior to implementing severity-adjusted DRGs, we would need specific legislative authority to offset any significant anticipated increase in payments attributable to changes in coding practices caused by significant changes to the DRG classification system. Section 301 of Public Law 106–554 authorized the Secretary to adjust the average standardized amounts if he determines that DRG coding or classification changes are likely to result in a change in aggregate payments. Therefore, based on this authority, we are beginning to evaluate the potential for implementing severity-adjusted DRGs. Because we are at the initial stages of that effort, we cannot yet estimate when, or if, such implementation may occur. However, we agree with these commenters' points that significant changes to any of the adjustments under the prospective payment system must be considered in light of the effects such changes may have to other such adjustments.

Comment: One commenter interpreted our proposal to suggest that the fiscal year for which the data will be collected will be closed by the time the methodology and data requirements have been established.

Response: In the proposed rule, we indicated we would conduct a special survey to collect these data to coincide with hospitals' cost reports beginning during FY 2001. We do not intend to require hospitals to retroactively adjust their payroll records to collect these data. Therefore, given our intention to gather input from the industry prior to designing the survey instrument, it likely will not be possible to completely coincide the data collection period with hospitals' FY 2001 cost reports.

Although there may be some auditing benefits to having the data overlap, this type of data is not routinely collected through the cost reports, so that the auditing benefits of such overlap may be minimal. In addition, there may be a benefit to collecting occupational mix for a more recent period in terms of reflecting current trends, such as higher wages paid to nurses during a shortage.

Comment: Other commenters raised specific technical concerns about the occupational mix discussion in the proposed rule.

Response: Rather than respond individually at this time to technical issues associated with the occupational mix discussion in the proposed rule, we will address these issues through direct consultation with the industry, as described above.

D. Verification of Wage Data From the Medicare Cost Report

The data for the FY 2002 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1998 Medicare cost reports. The data file used to construct the wage index includes FY 1998 data submitted to us as of July 2001. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2002 wage index have been resolved and are reflected in the calculation of the final FY 2002 wage index. We note that, as part of this process to identify aberrant data and correct any errors prior to the calculation of the final FY 2002 wage index, we notified by letter those hospitals that were leading to large variations in the wage indexes of their labor market areas compared to the FY 2001 wage index. These hospitals were advised to review their data to identify the reason for the large increases or decreases and notify their fiscal intermediary of any necessary corrections.

Also, as part of our editing process, in the final wage index, we removed data for 30 hospitals that failed edits. For 24 of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. Six hospitals had incomplete or inaccurate data resulting in exceptionally large, zero, or negative average hourly wages. Therefore, they were removed from the calculation. As a result, the final FY 2002 wage index is calculated based on FY 1998 wage data for 4,880 hospitals.

Comment: One commenter recommended that we incorporate additional fatal edits in the cost reporting systems to eliminate obvious errors on the Worksheet S–3 that result in incomplete or erroneous wage data that are difficult to correct 4 years later.

Response: We do not agree with the recommendation of the commenter. A separate desk review is performed for the wage index. The desk review, combined with the level two edits, is sufficient to provide fiscal intermediaries with information to identify discrepancies, such as zero or negative average hourly wage or missing hours, that can be resolved by the fiscal intermediary during the cost reporting process.

E. Computation of the FY 2002 Wage Index

We note a technical change to the FY 2002 calculation. For the FY 2001 wage index calculation, we initially proposed to subtract Line 13 of Worksheet S–3, Part III from total hours when determining the excluded hours ratio used to estimate the amount of overhead attributed to excluded areas (65 FR 26299). However, the formula resulted in large and inappropriate increases in the average hourly wages for some hospitals (65 FR 47074), particularly hospitals that have large overhead and excluded area costs. Therefore, for the final FY 2001 wage index calculation, we reverted to the FY 2000 excluded hours ratio formula, which did not subtract Line 13.

Subsequently, we analyzed how the application of this formula resulted in overstated average hourly wages for some hospitals and how we could improve the overall accuracy of the overhead allocation methodology. We became aware that the problem was not in the excluded hours ratio formula. Rather, our wage index calculation did not also remove the overhead wage-related costs associated with excluded areas, an amount that must be estimated before it can be subtracted from the calculation. The combined effect of applying the excluded hours ratio formula, which appropriately removes salaries of lower-wage, overhead employees, and not subtracting overhead wage-related costs associated with excluded areas, resulted in overstated salary costs and average hourly wages.

For the FY 2002 wage index calculation, we are applying the excluded hours ratio formula that subtracts Part III, Line 13 from total hours. Additionally, for the first time in the wage index calculation, we estimated and subtracted overhead wage-related costs allocated to excluded areas.

After we applied this new calculation, there were still a few hospitals that experienced large increases in their average hourly wages. The intermediaries verified that the hospitals' wage data were accurate, so we kept the data in the wage index calculation. These hospitals primarily function as SNFs, psychiatric hospitals, or rehabilitation hospitals that have few acute care beds. The hospitals' higher average hourly wages reflect the costs of the higher salaried employees that remain in the wage index calculation after we subtract the costs of excluded area and associated overhead employees.

The method used to compute the final FY 2002 wage index follows.

Step 1—As noted above, we based the FY 2002 wage index on wage data reported on the FY 1998 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1997 and before October 1, 1998. In addition, we included data from any hospital that had cost reporting periods beginning before October 1997 and reported a cost reporting period covering all of FY 1998. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1998 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1998 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1997 and before October 1, 1998), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 40 percent of the hospital's average hourly wage including all GME and CRNA costs, and 60 percent of the hospital's average hourly wage after eliminating all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, including all GME and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not

subject to the inpatient prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and physician Part A services (Lines 9, 9.01, 9.02, 10, and 10.01), home office salaries and wage-related costs reported by the hospital on Lines 11, 12, and 12.01, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, 18.01, and 20).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for specific categories of employees (Lines 16, 18, 18.01, and 20) are excluded if no corresponding salaries are reported for those employees (Lines 2, 4, 4.01, and 6, respectively).

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians, Lines (4.01, 10.01, 12.01, and 18.01), Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 3, 5, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 3, 5, and 7); (2) we computed overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, 16, 18, 18.01, and 20; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3. Using the above method for computing overhead salaries, wage-related costs, and hours to allocate to excluded areas, we also computed these costs excluding all costs associated with GME and CRNAs (Lines 2, 4.01, 6, 10.01, 12.01, and 18.01).

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1997 through April 15, 1999 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/97	11/15/97	1.03822
11/14/97	12/15/97	1.03561
12/14/97	01/15/98	1.03292
01/14/98	02/15/98	1.03048
02/14/98	03/15/98	1.02828
03/14/98	04/15/98	1.02621
04/14/98	05/15/98	1.02411
05/14/98	06/15/98	1.02200
06/14/98	07/15/98	1.01973
07/14/98	08/15/98	1.01714
08/14/98	09/15/98	1.01424
09/14/98	10/15/98	1.01137
10/14/98	11/15/98	1.00885
11/14/98	12/15/98	1.00669
12/14/98	01/15/99	1.00462
01/14/99	02/15/99	1.00239
02/14/99	03/15/99	1.00000
03/14/99	04/15/99	0.99746

For example, the midpoint of a cost reporting period beginning January 1, 1998 and ending December 31, 1998 is June 30, 1998. An adjustment factor of 1.01973 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1998 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 (with and without GME and CRNA costs) for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

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

Because the FY 2002 wage index is based on a blend of average hourly wages, we then added 40 percent of the average hourly wage calculated without removing GME and CRNA costs, and 60 percent of the average hourly wage calculated with these costs excluded.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $22.3096.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $10.7529 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the

Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2002, this change affects 217 hospitals in 40 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

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

1. Provisions of Public Law 106–554

Section 304 of Public Law 106–554 made changes to several provisions of section 1886(d)(10) of the Act relating to hospital reclassifications and the wage index:

• Section 304(a) amended section 1886(d)(10)(D) of the Act by adding a clause (v) to provide that, beginning with FY 2001, an MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 years, unless the hospital elects to terminate the reclassification. Section 304(a) also provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year (section 1886(d)(10)(D)(vi) of the Act).

• Section 304(b) provides that, by October 1, 2001, the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. Section 304(b) further requires that if the Secretary applies a statewide wage index to a State, an application under section 1886(d)(10) of the Act by an individual hospital in that State would not be considered.

We address our policy proposals relating to implementation of these three provisions of sections 304(a) and (b) of Public Law 106–554 in section IV.G. of this final rule. The following discussion of the revisions to the wage index based on hospital redesignations reflects those policies.

2. Effects of Reclassification

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

• If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.

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

• If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.

• The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

• Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.

• Rural areas whose wage index values increase as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index values calculated exclusive of the wage data of the redesignated hospitals.

• Currently, the wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area.

For the FY 2002 wage index, we include the wage data for a reclassified urban hospital in both the area to which it is reclassified and the MSA where the hospital is physically located. We believe this improves consistency and predictability in hospital reclassification and wage indexes, as well as alleviates the fluctuations in the wage indexes due to reclassifications. For example, hospitals applying to reclassify into another area will know which hospitals' data will be included in calculating the wage index, because even if some hospitals in the area are reclassified, their data will be included in the calculation of the wage index of the area where they are geographically located. Also, in some cases, excluding the data of hospitals reclassified to another MSA could have a large downward impact on the wage index of the MSA in which the hospital is physically located. The negative impact of removing the data of the reclassified hospitals from the wage index calculation could lead to large wage disparities between the reclassified hospitals and other hospitals in the MSA, as the remaining hospitals would receive reduced payments due to a lower wage index. Our approach is to promote consistency and simplify our rules with respect to how we construct the wage indexes of rural and urban areas. As noted above, in the case of rural hospitals redesignated to another area, the wage index of the rural area where the hospitals are geographically located is calculated by including the wage data of the redesignated hospitals (unless doing so would result in a lower wage index).

Finally, we note that the Medicare Payment Advisory Commission (MedPAC), in its March 2001 ''Report to the Congress: Medicare Payment Policy,'' recommended this policy (p. 82). (Section VII. of this preamble includes a discussion of MedPAC's recommendations and our responses.) To illustrate the potential negative impact on hospitals in an area where reclassifications of some hospitals to another area results in a decline in the wage index after the reclassified hospitals are excluded from the wage

index calculation, MedPAC points out that hospitals in several MSAs have organized to pay qualifying hospitals not to reclassify. Our policy change in this final rule removes this distorted incentive.

Comment: One commenter had some concerns about the reclassification of rural hospitals. This commenter had two points. The first point was that rural hospitals that seek reclassification to urban areas and end up ''empty'' because all the urban hospitals have successfully sought reclassification elsewhere continue to be disadvantaged because the rural hospitals continue to compete with the urban hospitals in that area, but those urban hospitals are receiving even higher payments, while the rural hospitals are not receiving the same payments. The commenter believed that the solution to this dilemma is to allow the rural hospitals that seek reclassification to an ''empty'' MSA to receive the same wage index as the urban hospitals that were able to reclassify out of that MSA, essentially reclassifying both the urban hospitals and the proximate rural hospitals to the same area. One other commenter made this same point about urban hospitals.

The commenter's second point was that, periodically, based on updated census data, new MSAs appear. Sometimes, a rural hospital seeking reclassification to the nearest MSA or rural area is disadvantaged when this occurs because reclassification to the new MSA does not afford the rural hospital the same advantages as reclassification to the MSA to which it formerly sought reclassification, but now is not the closest MSA. The commenter wrote that rural hospitals previously qualified for geographic reclassification to an MSA should retain the option to reclassify to that MSA despite the fact that a closer MSA is created.

Response: First, both rural and, for FY 2002, urban hospitals are advantaged by the fact that we hold all areas harmless when calculating the wage index for hospitals reclassifying into both MSAs and rural areas. While we understand the commenter's point about its competitors, we do not believe that this justifies a ''piggyback'' effect for reclassification purposes wherein either rural or urban hospitals that obtain reclassification into an empty MSA should then be reclassified again to an area to which these hospitals are not proximate. Since a hospital in this type of situation could not obtain reclassification on its own to the area to which the hospitals that have vacated the MSA have reclassified, we do not believe that it would be appropriate to reclassify them based on the reclassification of another hospital.

Second, a hospital that is not subject to the proximity criteria because it has a special status as either a rural referral center or a SCH already has an advantage over other reclassifying hospitals in that it can utilize a larger radius in seeking reclassification opportunities (under § 412.230(a)(3)). Rural referral centers and SCHs may also reclassify to any MSA to which they qualify under § 412.230(b). We believe these criteria provide adequate opportunity for rural referral centers and SCHs to reclassify.

Comment: Commenters generally supported our proposal to include the wage data for a reclassified urban hospital in both the area to which it is reclassified and the MSA where the hospital is physically located. The commenters expressed that this would provide more stability in the calculation of the wage index, allowing them to plan their budgets from year-to-year with more predictability.

We did not receive any negative comments on this proposal; however, we did receive one additional comment that encouraged us to extend the hold harmless provision to a further degree. This commenter believed that both rural and urban hospitals should benefit from the same hold-harmless policy. In other words, an urban hospital's wage data should be included in the area in which it is physically located if it benefits the area. However, The commenter further stated that, on the other hand, if it benefits the area to exclude that hospital's wage data in the event the hospital successfully seeks reclassification for the wage index to another area, then the hospital's data should be excluded. The commenter believed that some urban areas may be harmed by retaining the wage data of urban hospitals that are reclassifying out of those areas.

Response: We appreciate the commenters' support of our proposal to retain an urban hospital's wage data in the area in which it is physically located, even if that hospital successfully seeks reclassification to another area. As we proposed in the proposed rule, in this final rule we are calculating the wage index for urban areas effective for FY 2002 payments by including the wage data for a reclassified urban hospital in both the area to which it is reclassified and the MSA where the hospital is physically located.

In reference to the commenter who believed that we should apply the same hold-harmless policy to urban hospitals as we do to rural hospitals, we note that the rural hold-harmless policy (as described above) is dictated by section 1886(d)(8)(C)(iii) of the Act. We believe that hospitals continue to compete for services with the hospitals that are grouped with them in their respective MSAs. Therefore, it would be appropriate to continue to calculate the wage index for those areas as if those hospitals had not reclassified to another area. As a result, we intend to implement our policy to hold urban areas harmless to the extent that the wages of the hospitals that are physically located within urban areas will continue to be used in the compilation of the wage index whether or not these hospitals successfully seek reclassification elsewhere.

Comment: Several commenters expressed interest in utilizing the occupational mix data to apply for reclassification for the wage index. These commenters pointed out that, at one time, hospitals did have the option to use occupational mix data to seek reclassification for the wage index as those data were made available by the AHA. In addition to the other applicable criteria for reclassification, a hospital that applied for reclassification for the wage index using this criterion was required to show that its average hourly wage, based on occupational mix data, was 90 percent of the area to which it sought reclassification.

Response: Prior to requests for reclassification effective during FY 1999, a hospital could be reclassified for the wage index by showing that its average hourly wage weighted for occupational categories was at least 90 percent of the average hourly wage of the hospitals in the area to which it sought reclassification (in addition to the other applicable criteria for reclassification). Occupational mix data were available from the AHA; however, the AHA stopped collecting the data in 1993. Therefore, because there was no other suitable source of occupational mix data for hospitals to use, we eliminated the option for using this data effective with reclassification requests for FY 1999 (62 FR 45988).

Section 304(c) of Public Law 106–554 requires that the Secretary must provide for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. These data are to be collected by September 30, 2003. Section 304(c) also requires that the data are to be applied in the wage index by October 1, 2004. At that point, the data will be incorporated into a hospital's average

hourly wages. Therefore, the occupational mix data will be reflected in hospital reclassifications for the wage index as it is incorporated into the wage index data. In addition, as soon as viable occupational mix data become available, we will consider providing hospitals with the opportunity to use it to support their reclassification requests.

The wage index values for FY 2002 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value; that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

As mentioned earlier, section 304(a) of Public Law 106–554 amended section 1886(d)(10)(D) of the Act by adding a new clause (v) to provide that a reclassification of a hospital by the MGCRB for purposes of the wage index is effective for 3 years (instead of 1 year) unless, under procedures established by the Secretary, the hospital elects to terminate the reclassification before the end of the 3-year period. Section 304(a) of Public Law 106–554 also amended section 1886(d)(10)(D) of the Act to specify that, for applications for reclassification for the wage index for FYs 2003 and later, the MGCRB must base any comparison of the average hourly wage of the hospital with the average hourly wage for hospitals in the area in which it is located and the area to which it seeks reclassification, using data from the most recently published hospital wage survey (as of the date of the hospital's application), as well as data from each of the two immediately preceding surveys. (Our policies in this final rule to incorporate the provisions of section 304(a) of Public Law 106–554 in the regulations are addressed in section IV.G. of this final rule).

Consistent with the section 304(a) amendment, Tables 3A and 3B list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FY 1996, 1997, and 1998 wage data. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 1996 and FY 1997 cost reporting periods, as well as the FY 1998 period used to calculate the FY 2002 wage index. Table 2 also shows the 3-year average that the MGCRB will use to evaluate a hospital's application for reclassification for FY 2003 (unless that average hourly wage is later revised in accordance with § 412.63(w)(2)). The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously in this section) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

Applications for FY 2003 reclassifications are due to the MGCRB by September 4, 2001. (We note that, as of May 21, 2001, the new location and mailing address of the MGCRB and the Provider Reimbursement Review Board (PRRB) is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670. Also, please specify whether the mail is intended for the MGCRB or the PRRB.)

We indicated in the proposed rule that, at the time the proposed wage index was constructed, the MGCRB had completed its review of FY 2002 reclassification requests. The final FY 2002 wage index values incorporate all 643 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or section 1886(d)(10) of the Act for FY 2002. Since publication of the May 4 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

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

Under § 412.273, hospitals that have been reclassified by the MGCRB were permitted to withdraw their applications within 45 days of the publication of the May 4, 2001 proposed rule. The request for withdrawal of an application for reclassification that would be effective in FY 2002 had to be received by the MGCRB by June 18, 2001. A hospital that requested to withdraw its application may not later request that the MGCRB decision be reinstated.

In addition, because the 3-year effect of the amendment made by section 304(a) of Public Law 106–554 is applicable to reclassifications for FY 2001 (which had already taken place prior to the date of enactment of Public Law 106–554) and because the application process for reclassification for FY 2002 had already been completed by the date of enactment, we are deeming hospitals that are reclassified for purposes of the wage index to one area for FY 2001 and are reclassified for purposes of the wage index or the standardized amount to another area for FY 2002 to be reclassified to the area for which they applied for FY 2002, unless they elected to receive the wage index reclassification they were granted for FY 2001. Consistent with our application withdrawal procedures under § 412.273, we allowed hospitals that wished to receive, for FY 2002, the reclassification they were granted for FY 2001, to withdraw their applications by June 18, 2001 also.

Comment: Two commenters requested us to continue publishing the case-mix index because it assists hospitals in monitoring possible referral center qualifying status and in preparing applications for reclassification to use another area's standardized amount. (We also received numerous telephone calls with this request.)

Response: Prior to this year, the case-mix index was published in Table 3C. This index shows the average DRG relative weight for discharges from a prior fiscal year. Due to the requirement to publish so much additional average hourly wage data in Tables 2, 3A, and 3B, we stopped publishing the case-mix index beginning with the May 4, 2001 proposed rule.

In light of public comments and in balancing the requirements for additional publication of average hourly wage data, we will resume publishing the case-mix index, but not in the **Federal Register**. Beginning with the publication date of this final rule, we will make the case-mix index for FY 2000 and future fiscal years available on

the internet at: http://www.hcfa.gov/medicare/ippsmain.htm. We intend to update the case-mix index at this website to coincide with the publication of the annual proposed and final rules.

3. Statewide Wage Index

As stated earlier, section 304(b) of Public Law 106–554 requires the Secretary to establish, by October 1, 2001, a process (based on the voluntary process utilized by the Secretary under section 1848 of the Act) under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, beginning in FY 2003. Section 304(b) further requires that, if the Secretary applies a statewide wage index to an area, an application by an individual hospital in that area would not be considered. We believe the reference to the voluntary process utilized by the Secretary under section 1848 of the Act refers to the process whereby we allow a State containing multiple physician fee schedule payment areas (and thus multiple geographic adjustment factors) to voluntarily convert to a single statewide payment area with a single geographic adjustment factor (see § 414.4(b), as discussed in the June 24, 1994 **Federal Register** (59 FR 32759).

Section IV.G. of this final rule contains our policy for implementing the provisions of section 304(b) in regulations. We are providing that hospitals that seek a statewide geographic reclassification under the amendments made by section 304(b) of Public Law 106–554 must apply to the MGCRB with the same deadlines as other hospitals. An approved application by the MGCRB will mean that the data of all the hospitals in the State will be used in computing and applying the wage index for that State. We are providing that the statewide wage index is applicable for 3 years from the date of approval or until all of the participating hospitals terminate their approved statewide wage index reclassification (effective with the next full fiscal year after their termination request), whichever occurs first.

4. Section 402 of Public Law 106–113

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

During FY 1994, we incorporated the revised MSA definitions based on 1990 census population data. As a result, some counties that previously were treated as an adjacent county under section 1886(d)(8)(B) of the Act officially became part of certain MSAs. However, as specified in the Act, we continued to utilize the January 3, 1980 standards. For FY 2000, there were 27 hospitals in 22 counties affected by this provision.

On March 30, 1990, OMB issued revised 1990 standards (55 FR 12154). There has been an increasing amount of interest by the hospital industry in using the 1990 standards as opposed to the 1980 standards to determine which hospitals qualify under the provisions set forth in section 1886(d)(8)(B) of the Act. Section 402 of Public Law 106–113 provides that, with respect to FYs 2001 and 2002, a hospital may elect to have the 1990 standards applied to it for purposes of section 1886(d)(8)(B) and that, beginning with FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of OMB based on the most recent decennial census.

We worked with staff of the Population Distribution Branch within the Population Division of the Census Bureau to compile a list of hospitals that meet the March 30, 1990 standards using 1990 census population data and information prepared for the Metropolitan Area Standards Review Project. The conditions that must be met for a hospital located in a rural county adjacent to one or more urban areas to be treated as being located in the urban area to which the greatest number of workers in the rural county commute are as follows:

- The rural county would otherwise be considered part of an MSA but for the fact that the rural county does not meet the standard established by OMB relating to the commuting rate of workers between the county and the central county or counties of any adjacent MSA.
- The county would meet the commuting standard if commuting to (and where applicable, from) the central county or central counties of all adjacent MSAs or NECMAs (rather than to just one) were considered.

A county meeting the above commuting standards must also meet the other standards established by OMB for inclusion in an MSA as an outlying county. In order to meet these requirements, the rural county must have a degree of ''metropolitan character.'' ''Metropolitan character'' is established by meeting one of the following OMB standards, which were published in the **Federal Register** on March 30, 1990:

a. At least 50 percent of the employed workers residing in the county commute to the central county/counties, and either—

- The population density of the county is at least 25 persons per square mile; or
- At least 10 percent of the population, or at least 5,000 persons, lives in the qualifier urbanized area(s).

b. From 40 to 50 percent of the employed workers commute to the central county/counties, and either—

- The population density is at least 35 persons per square mile; or
- At least 10 percent of the population, or at least 5,000 persons, lives in the qualifier urbanized area(s).

c. From 25 to 40 percent of the employed workers commute to the central county/counties and either the population density of the county is at least 50 persons per square mile, or any two of the following conditions exist:

- Population density is at least 35 persons per square mile.
- At least 35 percent of the population is urban.
- At least 10 percent of the population, or at least 5,000 persons, lives in the qualifier urbanizer area(s).

d. From 15 to 25 percent of the employed workers commute to the central county/counties, the population density of the county is at least 50 persons per square mile, and any two of the following conditions also exist:

- Population density is at least 60 persons per square mile.
- At least 35 percent of the population is urban.
- Population growth between the last two decennial censuses is at least 20 percent.
- At least 10 percent of the population, or at least 5,000 persons, lives in the qualifier urbanized area(s).

Also accepted as meeting this commuting requirement under item d. are:

• The number of persons working in the county who live in the central county/counties is equal to at least 15 percent of the number of employed workers living in the county; or

• The sum of the number of workers commuting to and from the central county/counties is equal to at least 20 percent of the number of employed workers living in the county.

e. From 15 to 25 percent of the employed workers commute to the central county/counties, the population density of the county is less than 50 persons per square mile, and any two of the following conditions also exist:

• At least 35 percent of the population is urban.

• Population growth between the last two decennial censuses is at least 20 percent.

• At least 10 percent of the population, or at least 5,000 persons, lives in the qualifier urbanized area(s).

f. At least 2,500 of the population lives in a central city of the MSA located in the qualifier urbanized area(s).

When we apply the 1990 standards as opposed to 1980 standards, the number of qualifying counties increases from 22 to 31. On the basis of the evaluation of these data, effective for discharges occurring on or after October 1, 2001, hospitals listed in the first column of the following table are considered, for purposes of assigning the inpatient standardized amount and the wage index, to be located in the corresponding urban area in the second column:

Rural county	MSA
Chilton, AL	Birmingham, AL
Marshall, AL	Huntsville, AL
Talladega, AL	Anniston, AL
Bradford, FL	Jacksonville, FL
Hendry, FL	West Palm Beach-Boca Raton, FL
Putnam, FL	Gainesville, FL
Jackson, GA	Athens, GA
Christian, IL	Springfield, IL
Macoupin, IL	St. Louis, MO–IL
Piatt, IL	Champaign-Urbana, IL
Brown, IN	Indianapolis, IN
Carroll, IN	Lafayette, IN
Henry, IN	Indianapolis, IN
Jefferson, KS	Topeka, KS
Barry, MI	Kalamazoo-Battle Creek, MI
Cass, MI	Benton Harbor, MI
Ionia, MI	Grand Rapids-Muskegon-Holland, MI
Shiawassee, MI	Flint, MI
Tuscola, MI	Saginaw-Bay City-Midland, MI
Caswell, NC	Greensboro-Winston Salem-High Point, NC
Greene, NC	Greenville, NC
Harnett, NC	Raleigh-Durham-Chapel Hill, NC
Wilson, NC	Rocky Mount, NC
Preble, OH	Dayton-Springfield, OH
Van Wert, OH	Lima, OH
Adams, PA	York, PA
Lawrence, PA	Pittsburgh, PA
Monroe, PA	Newark, NJ
Schuylkill, PA	Reading, PA
Jefferson, WI	Milwaukee-Waukesha, WI
Walworth, WI	Milwaukee-Waukesha, WI

There are 14 counties that meet the qualifying criteria using 1990 standards that did not meet the criteria using the 1980 standards. These 14 counties are:

Chilton, AL
Talladega, AL
Bradford, FL
Hendry, FL
Putnam, FL
Jackson, GA
Piatt, IL
Brown, IN
Carroll, IN
Greene, NC
Wilson, NC
Adams, PA
Monroe, PA
Schuylkill, PA.

In addition, when we apply the 1980 standards for three of the counties, the MSA assigned is different from the MSA that would be assigned using the 1990 standards. These counties are as follows:

Rural county	1980 MSA designation	1990 MSA designation
Ionia, MI	Lansing-East Lansing, MI	Grand Rapids-Muskegon-Holland, MI.
Caswell, NC	Danville, VA	Greensboro-Winston Salem-High Point, NC.
Harnett, NC	Fayetteville, NC	Raleigh-Durham-Chapel Hill, NC.

Section 402 of Public Law 106–113 states that hospitals may elect to use either the January 3, 1980 standards or the March 30, 1990 standards for payments during FY 2001 and FY 2002. We are assuming hospitals will elect to go to the MSA resulting in the highest payment amount accounting for the applicable wage indexes and standardized amounts. Based on our analysis, we believe all hospitals in the designated rural counties would benefit by being included in the respective MSAs shown above. Therefore, we proposed to assign the FY 2002

standardized amount and wage index of each respective MSA to the affected hospitals. Hospitals electing not to use the 1990 standards would be required to notify their fiscal intermediary in writing of such election prior to September 1, 2001, in order to allow sufficient time to reflect this change in our payment systems.

We note that five rural counties no longer meet the qualifying criteria when we apply the revised OMB standards. These rural counties are as follows: Indian River, FL; Mason, IL; Owen, IN; Morrow, OH; and Lincoln, WV. For FY 2002, we continue to treat these hospitals as attached to an MSA on the basis of the 1980 standards. Beginning FY 2003, they must meet the 1990 standards to continue to be treated as such.

We stated in the August 1, 2000 final rule that implemented changes to the prospective payment system for FY 2001 that we were in the process of working with OMB to identify the hospitals that would be affected by section 402 of Public Law 106–113 (65 FR 47076). We further indicated we would revise payments to hospitals in the affected counties as soon as data were available. Now that the affected counties have been identified, hospitals in the 14 counties identified above will be offered the opportunity to elect this designation, as previously described. We will provide further information related to this election, including recalculated wage indexes, through a forthcoming program memorandum.

Finally, three hospitals located in counties affected by the revised OMB standards also have been reclassified by the MGCRB. The affected hospitals are listed below. If the hospitals did not wish to be reclassified for FY 2002 based on their new designation as described above, they had to follow the procedures described above for requesting that their application for reclassification be withdrawn.

Provider No.	1990 MSA Designation	FY 2002 reclassification, MSA
34–0071	Raleigh-Durham-Chapel Hill, NC	Fayetteville, NC.
34–0124	Raleigh-Durham-Chapel Hill, NC	Fayetteville, NC.
34–0126	Rocky Mount, NC	Raleigh-Durham-Chapel Hill, NC (wage index only).

5. Provisions of the August 1, 2000 Interim Final Rule: Sections 152(a), 153, and 154a) of Public Law 106–113

In the August 1, 2000 interim final rule with comment period, we implemented sections 152(a), 153, and 154(a) of Public Law 106–113. These sections contained provisions under which hospitals in certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring during FY 2000. For payment purposes, hospitals under section 152(a) are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. Sections 153 and 154(a) did not affect the standardized amount. In the interim final rule, we calculated FY 2000 wage indexes for hospitals in the affected counties. These wage indexes are listed below. No other hospitals' FY 2000 wage indexes were affected, including those hospitals in the areas to which these affected hospitals were reclassified, as well as nonreclassified hospitals located in the areas from which these hospitals were reclassified.

We also implemented section 152(a), which provided that, for purposes of making payments under section 1886(d) of the Act for FY 2000—

- To hospitals in Iredell County, North Carolina, Iredell County was deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- To hospitals in Orange County, New York, Orange County was deemed to be located in the New York, New York MSA;
- To hospitals in Lake County, Indiana and Lee County, Illinois, Lake County and Lee County were deemed to be located in the Chicago, Illinois MSA;
- To hospitals in Hamilton-Middletown, Ohio, Hamilton-Middletown was deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- To hospitals in Brazoria County, Texas, Brazoria County was deemed to be located in the Houston, Texas MSA;
- To hospitals in Chittenden County, Vermont, Chittenden County was deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

In accordance with section 153 of Public Law 106–113, for discharges occurring during FY 2000, the Hattiesburg, Mississippi MSA wage index was recalculated by including the wage data for Wesley Medical Center. In accordance with section 154(a), the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index was recalculated by including the wage data for Lehigh Valley Hospital.

The following table shows the changes to the FY 2000 wage index values for the hospitals in the affected counties. Hospitals affected by section 152(a) of Public Law 106–113 were also considered reclassified for purposes of the standardized amount.

County or MSA	New MSA (for wage index and standardized amount)	New wage index	New Georgraphic Adjustment Factor (GAF)
Iredell County, NC	1520	0.9434	0.9609
Orange County, NY	5600	1.4342	1.2801
Lake County, IN	1600	1.0750	1.0508
Lee County, IL	1600	1.0750	1.0508
Hamilton-Middletown, OH	1640	0.9419	0.9598
Brazoria County, TX	3360	0.9388	0.9577
Chittenden County, VT	1123	1.1359	1.0912
Hattiesburg, MS MSA	3285	0.7634	0.8312
Allentown-Bethlehem-Easton, PA MSA	0240	1.0228	1.0156

G. Requests for Wage Data Corrections

In the May 4, 2000 proposed rule, we stated that, to allow hospitals time to construct the proposed FY 2002 hospital wage index, we would make available in May 2001 a final public data file containing the FY 1998 hospital wage data.

The final wage data file was released on May 4, 2001. As noted above in section III.D. of this preamble, this file included hospitals' cost report data obtained from Worksheet S–3, Parts II and III of their FY 1998 Medicare cost reports. In addition, Table 2 in the Addendum to this final rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 1998 data used to construct the final FY 2002 wage index.

Under revised procedures, hospitals were given an opportunity to correct any incorrectly reported FY 1998 wage data on their cost reports and submit complete detailed supporting documentation to their intermediaries by March 9, 2001. Wage data corrections had to be reviewed and verified by the intermediary and transmitted to HCFA on or before April 9, 2001. These deadlines were necessary to allow sufficient time to review and process the data so that the final wage index calculation could be completed for development of the final prospective payment rates in this final rule.

We created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2002 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above were not afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to later challenge, before the Provider Reimbursement Review Board, HCFA's failure to make a requested data revision (See *W. A. Foote Memorial Hospital v. Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001)).

As stated above, the final wage data public use file was released on May 4, 2001. Hospitals had an opportunity to examine both Table 2 of the proposed rule and the May 4 final public use wage data file (which reflected revisions to the data used to calculate the values in Table 2) to verify the data HCFA was using to calculate the wage index. Hospitals had until June 4, 2001, to submit requests to correct errors in the final wage data due to data entry or tabulation errors by the intermediary or HCFA. The correction requests considered at that time were limited to errors in the entry or tabulation of the final wage data that the hospital could not have known about before the release of the final wage data public use file.

If, after reviewing the May 2001 final data file, a hospital believed that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and HCFA, outlining why the hospital believed an error exists and provide all supporting information, including dates. These requests had to be received by us and the intermediaries no later than June 4, 2001.

Changes to the hospital wage data were made in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor HCFA accepted the following types of requests at that stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCFA on or before April 9, 2001.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 2001 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 4, 2001) are incorporated into the final wage index in this final rule, to be effective October 1, 2001.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals had access to the final wage data by early May 2001, they had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2002 wage index and its implementation on October 1, 2001. If hospitals availed themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2002 (that is, by the June 4, 2001 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the intermediary notified the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be necessary. However, should a midyear correction be necessary, the wage index-change for the affected area will be effective prospectively from the date the correction is made.

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

Although the wage data correction process described above has proven successful in the past for ensuring that the wage data used each year to calculate the wage indexes are generally reliable and accurate, we are concerned about the growing volume of wage data revisions initiated by hospitals during February and the first week of March. We first discussed this issue in the FY 1998 proposed rule (62 FR 29918). At that time, we noted that, in developing the FY 1997 wage index, the wage data were revised between the proposed and final rules for more than 13 percent of the hospitals (approximately 700 of 5,200). Last year, in developing the FY 2001 wage index, the wage data were revised between the proposed and final rules for more than 32 percent of the hospitals (1,605 of 4,950). This year, in developing the FY 2002 wage index, the wage data were revised between the proposed rule and the final rule for 30 percent of the hospitals (1,473 of 4,910).

In the May 4, 2001 proposed rule, we indicated that since hospitals are expected to submit complete and accurate cost report data, and intermediaries review and request hospitals to correct problematic wage data before the data are submitted to HCFA in mid-November, we believed there should be limited revisions at this stage of the process. We reminded the hospital community that the primary purpose of this file is to allow hospitals to verify that we have their correct data on file. However, according to information received from the intermediaries, these late revisions are frequently due to hospitals' lack of responsiveness in providing sufficient information to the intermediaries during the desk reviews (that is, during the

intermediary's review of the hospital's cost report).

In the proposed rule, we proposed two changes to the wage index development process and timetable beginning with the FY 2003 wage index. We believed these changes would encourage earlier submissions of wage data revisions by hospitals and would allow intermediaries more time to address the heavy volume of revisions requested after the intermediaries have completed their desk reviews of these data. First, we proposed to release the preliminary wage data file by early January rather than early February. As with the current preliminary file, the January file would include desk reviewed wage data that intermediaries submitted to us by November of the previous year and any timely revisions we received from intermediaries prior to release of the January file. Hospitals would be allowed until early February to submit requests for wage data revisions to their intermediaries. Second, intermediaries would be allowed approximately 8 weeks from the hospitals' deadline for submitting revision requests (that is, until early March) to review and transmit revised wage data to us.

We believed that the proposed revised schedule would improve the quality of the wage index by allowing intermediaries more time to sufficiently review wage data revisions before the data are submitted to us. Further, we believed the proposed revised process would encourage hospitals to submit revisions earlier, so the proposed wage index, from which hospitals base geographic reclassification decisions, is more accurate.

The timetable for developing the annual update to the wage index is as follows (an asterisk indicates no change from prior years):

Mid-November *

All desk reviews for hospitals wage data are completed and revised data transmitted by the fiscal intermediaries to HCRIS.

Early December *

CMS compiles file of wage data, received by mid-November, and sends it to the fiscal intermediaries for verification.

Early January

Edited wage data are available for release to the public.

Early February

Deadline for hospitals to request wage data revisions and provide adequate documentation to support the request.

April/May *

Proposed rule published with 60-day comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.

Early April *

Deadline for the fiscal intermediaries to submit all revisions resulting from the hospitals' requests for adjustments (as of early February) (and verification of data submitted as of early January).

Deadline for hospital's to request CMS's intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations pertaining to the allowability of particular costs.

Late April *

Fiscal intermediaries will alert hospitals to the availability of the final wage data file for their review and inform hospitals of the June deadline for hospitals to submit correction requests for corrections to errors due to CMS or fiscal intermediary mishandling of the final wage data.

Early May *

Release of final wage data public use file on CMS web page and through public use files office.

Early June *

Deadline for hospitals to submit correction requests to both CMS and the fiscal intermediaries to correct errors due to CMS or fiscal intermediary mishandling of the final wage data.

August 1 *

Publication of the final rule.

October 1 *

Effective date of updated wage index.

Comment: One commenter agreed, in general, with the premise of the proposed revised schedule. The commenter recommended that we publish the preliminary wage data file in August, using data from the hospitals' as-filed cost reports before fiscal intermediaries begin the wage index desk reviews. Hospitals would then have until October 1 to submit requests, along with supporting documentation, to correct errors. The commenter's proposal would give fiscal intermediaries until November 30 to complete the desk review and transmit the wage index data to us. The commenter believed that implementation of the recommended schedule eliminates the fiscal intermediary's duplication of effort (that is, reviewing the data a second time when hospitals request changes after the desk review, and then resubmitting the data to us) that exists in the current process.

Response: We appreciate the commenter's general support for our proposal to revise the wage index schedule, and we will give the commenter's recommended process careful consideration in developing future updates to the wage index. Having received no other comments opposing our proposed schedule, we will implement that schedule, beginning with the FY 2003 wage index. We believe that our revised schedule is a logical step in the evolution of the wage index development process. We will monitor the effectiveness of the revised schedule.

IV. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Sole Community Hospitals (SCHs) (§§ 412.63, 412.71, 412.72, 412.73, 412.75, 412.77, and 412.92)

For the benefit of the reader, in this final rule, we are discussing and clarifying many of the rules and policies governing SCHs because of the legislative changes that have occurred in recent years. It has been several years since the SCH criteria have been published in one location. Rather than continue to refer to various **Federal Register** documents and sections of the Code of Federal Regulations, we are publishing a detailed discussion of these policies, making further changes to incorporate the provisions of sections 213, 302, 303, 304, and 311 of Public Law 106–554, and clarifying other related policies.

Under the hospital inpatient prospective payment system, special payment protections are provided to an SCH. Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an Essential Access Community Hospital (EACH), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are at § 412.92. To be classified as an SCH, a hospital must either have been designated as an SCH prior to the beginning of the prospective payment system on October 1, 1983, and must be located more than 35 miles from other like hospitals, or the hospital must be

located in a rural area and meet one of the following requirements:

• It is located more than 35 miles from other like hospitals.

• It is located between 25 and 35 miles from other like hospitals, and it—

—Serves at least 75 percent of all inpatients, or 75 percent of Medicare beneficiary inpatients, within a 35-mile radius or, if larger, within its service area; or

—Has fewer than 50 beds and would qualify on the basis of serving 75 percent of its area s inpatients except that some patients seek specialized care unavailable at the hospital.

• It is located between 15 and 25 miles from other like hospitals, and because of local topography or extreme weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years.

• The travel time between the hospital and the nearest like hospital is at least 45 minutes because of distance, posted speed limits, and predictable weather conditions.

Effective with hospital cost reporting periods beginning on or after April 1, 1990, section 1886(d)(5)(D)(i) of the Act, as amended by section 6003(e) of Public Law 101–239, provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment:

• The Federal rate applicable to the hospital.

• The updated hospital-specific rate based on FY 1982 costs per discharge.

• The updated hospital-specific rate based on FY 1987 costs per discharge.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, section 1886(b)(3)(I)(i) of the Act, as added by section 405 of Public Law 106–113 and amended by section 213 of Public Law 106–554, provides for other options, in addition to the three bulleted options in the above paragraph, for determining which rate would yield the greatest aggregate payment. For discharges for FY 2001 through FY 2003, these additional optional rates are—

• A phase-in blended rate of the updated hospital-specific rate based on FY 1982 costs per discharge and an FY 1996 hospital-specific rate; or

• A phase-in blended rate of the updated hospital-specific rate based on FY 1987 costs per discharge and an FY 1996 hospital-specific rate.

For discharges beginning in FY 2004, the additional optional rate would be 100 percent of the FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period to determine precisely which of the payment rates would yield the highest payment to the hospital.

If a hospital disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

In calculating a hospital-specific rate for an SCH based on its FY 1996 cost reporting period, we will, to the extent possible, use the same methodology that we used to calculate the hospital-specific rate based on either the FY 1982 or FY 1987 cost reporting period. That methodology is set forth in §§ 412.71, 412.72, 412.73, 412.75 and 412.77.

• If a hospital has a cost reporting period ending in FY 1982, it will be paid a hospital-specific rate based on its FY 1982 costs; or a hospital-specific rate based on its FY 1987 costs; or a hospital-specific rate based on its FY 1996 costs (which, until FY 2004, would be a blend of the greater of the FY 1982 or FY 1987 costs and the FY 1996 costs); or it will be paid based on the Federal rate.

• If a hospital has no cost reporting period ending in FY 1982, it will be paid a hospital-specific rate based on its FY 1987 costs; or a hospital-specific rate based on its FY 1996 costs (which, until FY 2004, would be a blend of its FY 1987 costs and FY 1996 costs); or it will be paid based on the Federal rate.

• If a hospital has no cost reporting period ending in either FY 1982 or FY 1987, it will be paid based on its FY 1996 costs; or it will be paid based on the Federal rate.

• If a hospital has no cost reporting period ending in FY 1982, FY 1987, or FY 1996, it cannot be paid based on a hospital-specific rate; it will be paid based on the Federal rate.

• If a hospital was operating during any or all of FY 1982, FY 1987, or FY 1996, but, for some reason, the cost report records are no longer available, the hospital will be treated as if it had no cost report for the applicable period. Section 1886(b)(3)(C) of the Act specifies the available periods that may be used.

For each SCH, the fiscal intermediary will calculate a hospital-specific rate based on the hospital's FY 1982, FY 1987, or FY 1996 cost report as follows:

• Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the cost report.

• Divide the total Medicare operating cost by the number of Medicare discharges (without adjusting for transfers) in the cost reporting period to determine the base period cost per case.

• In order to take into consideration the hospital's individual case-mix, the base year cost per case is divided by the hospital's case-mix index applicable to the cost reporting period. This step is necessary to adjust the hospital's base period cost for case mix. This is done to remove the effects of case mix from the base period costs per case. Payments using these base period costs are then adjusted to reflect the actual case mix during the payment year. A hospital's case mix is computed based on its Medicare patient discharges subject to DRG-based payment.

The fiscal intermediary will inform each SCH of its hospital-specific rate based on its applicable cost reporting period within 180 days after the start of its cost reporting period.

(The provisions of section 213 of Public Law 106–554 relating to the extension to all SCHs the option to rebase using their FY 1996 operating costs, for cost reporting periods beginning on or after October 1, 2000, were addressed in the June 13, 2001 interim final rule with comment period, and are finalized in this final rule.)

An SCH is also eligible for a payment adjustment if, for reasons beyond its control, it experiences a decline in volume of greater than 5 percent compared to its preceding cost reporting period. This adjustment is also available to hospitals that could qualify as SCHs but choose not to be paid as SCHs; that is, hospitals that qualify and successfully apply to be designated as SCHs but continue to receive payments based on the Federal rate. In addition, section 6003(c)(1) of Public Law 101–239 deleted the sunset date on the 5-percent volume decline adjustment, thus allowing SCHs to receive the adjustment indefinitely. The sunset provision was included under section 1886(d)(5)(C)(ii) of the Act. (Section 6003(c)(1) of Public Law 101–239 amended that provision and

redesignated it as section 1886(d)(5)(D) of the Act.)

In the September 1, 1983, issue of the **Federal Register** (48 FR 39781), we stated that any hospital designated as an SCH would retain that status until it experienced a change in circumstances. Section 6003(e)(3) of Public Law 101–239 specifically stated that any hospital classified as an SCH as of the date of enactment of Public Law 101–239 (December 19, 1989), will retain its SCH status even if the hospital did not meet the criteria established under section 6003(e)(1) of that law. These hospitals are the ''grandfathered'' SCH hospitals. Therefore, we have continued to allow hospitals designated as SCHs prior to December 19, 1989, to be ''grandfathered'' under current criteria.

In the June 4, 1991 **Federal Register**, we stated that a hospital's special status as an SCH would not be retained in light of the hospital's geographic reclassification for purposes of the standardized amount. In the event the hospital's reclassification ceases, it must reapply for special status and must meet all of the applicable qualifying criteria in effect at the time it seeks requalification (56 FR 25482). However, in the event a ''grandfathered'' SCH was successfully reclassified, it would be reinstated as an SCH if its reclassification ceased.

Section 401(a) of Public Law 106–113 established that any subsection (d) hospital (section 1886(d) of the Act) located in an urban area may be redesignated as being located in a rural area if the hospital meets one of several criteria established by the legislation. One of these criteria is that the hospital could qualify as an SCH if the hospital were located in a rural area. Under this provision, an urban hospital that may have been ''grandfathered'' as an SCH could now qualify and receive payment as an SCH if it met the criteria of a rural SCH instead of as an urban SCH. Given this extension of SCH eligibility, we no longer believe it is necessary to extend special protection to ''grandfathered'' SCHs that successfully apply for geographic reclassification through the MGCRB for the standardized amount after their MGCRB reclassification ends. Therefore, a hospital that loses its SCH status through a change in circumstances, such as reclassification through the MGCRB for the standardized amount, will not be reinstated as a SCH unless it can meet all of the SCH qualifying criteria in effect at the time it seeks requalification. This circumstance falls under the provisions of §§ 412.92 (b)(3) and (b)(5), which state that an approved classification as an SCH remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. We believe that a successful reclassification by the MGCRB fits the definition of a change in circumstances.

Because some hospitals may not have understood the effect reclassification would have on their special status, in the May 4 proposed rule we permitted affected hospitals, under existing § 412.273(a), the option to withdraw their applications for reclassification for FY 2002, even if the MGCRB had issued a decision, by submitting a withdrawal request to the MGCRB within 45 days of publication of this proposed rule. Finally, just as a competing hospital that closes leaves an opportunity for an existing hospital to qualify as an SCH, a new hospital that opens in an area with an existing hospital designated as an SCH endangers the SCH status of the existing hospital.

As of October 1, 1997, no designations of hospitals as EACHs can be made. The EACHs designated by CMS before October 1, 1997, will continue to be paid as SCHs for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

Under § 412.92(b)(2), we define the effective dates for several situations in which a hospital gains or gives up SCH status. First, SCH status and the associated payment adjustment is effective 30 days after CMS's written notification to the SCH. Thus, 30 days after the issuance of CMS's notice of approval, the hospital is considered to be an SCH and the payment adjustment is applied to discharges occurring on or after that date.

Second, § 412.92(b)(4)(ii) defines the effective date when a hospital chooses to give up its SCH status. Our policy has always been that an SCH can elect to give up its SCH status at any time by submitting a written request to the appropriate CMS regional office through its fiscal intermediary. The change to fully national rates becomes effective no later than 30 days after the hospital submits its request. We believe that the ''no later than 30 days'' policy for the effective date for cancelling SCH status is in keeping with the prospective nature of the prospective payment system. In addition, the 30-day timeframe to give up SCH status provides the fiscal intermediaries with enough time to alter their automated payment systems prospectively, thus avoiding expensive and time-consuming reprocessing of claims. The variable timeframe of ''no later than 30 days from the date of the hospital's request'' also permits the regional office, the fiscal intermediary, and the hospital to select a mutually agreeable date, for example, at the end of a month, to facilitate the change in SCH status. We expect that hospitals will anticipate when they wish to give up SCH status and to submit their requests in sufficient time to permit the 30-day period for making the change.

In addition, § 412.92(b)(2)(ii) defines the effective date of SCH status in the situation where a final and nonappealable administrative or judicial decision reverses CMS's denial of SCH status to a hospital. In this situation, if the hospital's application was submitted on or after October 1, 1983, the effective date will be 30 days after the date of CMS's original written notification of denial.

Under § 412.92(b)(2)(iii), we define retroactive approval of SCH status. If a hospital is granted retroactive approval of SCH status by a final and nonappealable court order or an administrative decision under subpart R of part 405 of the regulations, and it wishes its SCH status terminated prior to the current date (that is, it wishes to be paid as an SCH for a time-limited period, all of which is in the past), it must submit written notice to the CMS regional office through its fiscal intermediary within 90 days of the court order or the administrative decision. This written notice must clearly state that, although SCH status was granted retroactively by the court order or by the administrative decision, the hospital wants this status terminated as of a specific date. If written notice is not received within 90 days of the court order or the administrative decision, SCH status will continue. Written requests to terminate SCH status that are received subsequent to the 90-day period will be effective no later than 30 days after the request is submitted, as discussed above.

Under § 412.92(c)(1), we define mileage. We believe that mileage should continue to be measured by the shortest route over improved roads maintained by any local, State, or Federal government entity for public use. We consider improved roads to include the paved surface up to the front entrance of the hospital because this portion of the distance is utilized by the public to access the hospital. This definition provides consistency with the interpretation of the MGCRB when considering hospital reclassification applications. The MGCRB measures the distance between the hospital and the county line of the area to which it seeks reclassification beginning with the paved area outside the front entrance of

the hospital. This provides a consistent, national definition that is easily recognizable for each hospital. Finally, rounding of mileage is not permissible. This is also consistent with the MGCRB definition of mileage (56 FR 25483). In this final rule, we are revising the definition of ''miles'' under § 412.92(c)(1) to state that an improved road includes the paved surface up to the front entrance of the hospital.

Under § 412.92(c)(2), we define ''like'' hospital. We consider like hospitals to be those hospitals furnishing short-term acute care. That is, a hospital may not qualify for an SCH classification on the grounds that neighboring hospitals offer specialty services, thereby seeking to exclude close-by competitors as like hospitals, in order to meet the mileage criteria by measuring to a like hospital that is located further away. For example, we believe that competing hospitals within a given area may each have their own specialty services, while all the facilities continue to be considered short-term acute care hospitals. We note that under § 412.92(a)(1)(ii), a hospital with fewer than 50 beds may qualify for SCH status under a special provision if patients that it would normally serve are seeking care elsewhere due to the unavailability of specialty services. This means that, if a hospital can prove that the patients from its service area are seeking specialty services elsewhere (such as, among others, heart surgery, transplants, and burn care), rather than routine care, and, because of that fact, that it otherwise would have met the criteria of section § 412.92(a)(1)(i), it can qualify as an SCH.

We note that § 412.92(b)(1)(iii)(A) retains an outdated reference to ''hospitals located within a 50 mile radius of the hospital.'' With the issuance of the September 1, 1989 **Federal Register** (54 FR 36481, 36482), the 50 mile radius was determined to be unreasonable and all references should have been changed to 35 miles in accordance with § 412.92(a)(1)(i). In this final rule. we are revising the reference to ''a 50 mile radius'' in § 412.92(b)(1)(iii)(A) to read ''a 35 mile radius''.

We note that the travel time and weather conditions criteria set forth in § 412.92(a)(3) were discussed in detail in the September 4, 1990 **Federal Register** (55 FR 36050 through 36055 and 36162 through 36163).

Under § 412.92(a)(1)(i) and (b)(1)(ii), we define the market area analysis criteria used to determine SCH status. In the May 4, 2001 proposed rule, we discussed several points concerning these requests for SCH status that we proposed to clarify.

First, a hospital seeking an SCH designation based on these criteria must make its initial request to the fiscal intermediary with all the appropriate documents as will be discussed below (§ 412.92(b)(1)(i)). The fiscal intermediary will make a recommendation on the request, based on receipt of all the appropriate documentation and its own investigation and analysis, and that recommendation will be forwarded to the CMS regional office for another level of review and final approval or disapproval. The fiscal intermediary would forward its recommendation to the CMS regional office located in the hospital's area as opposed to the fiscal intermediary's area, if there is a difference in these areas. As discussed above, an approval of the request for SCH status will be effective 30 days after CMS issues the approval letter. If a determination on the request requires the use of data that are available at CMS central office only, upon receipt of the fiscal intermediary's recommendation, the CMS regional office will forward the request and the fiscal intermediary's recommendation to the appropriate contact at CMS central office where the determination will be made.

Second, a hospital must provide patient origin data (the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area (§ 412.92(b)(1)(ii)(A)). Or, the hospital can request that CMS develop patient origin data to define its service area based on the number of patients from each zip code from which the hospital draws Medicare Part A inpatients (§ 412.92(b)(1)(iii)). Then, the lowest number of zip codes in descending percentage order of Medicare inpatients that meets the 75-percent threshold will be used to represent the hospital's service area. We note that hospitals cannot substitute zip codes elsewhere on the list in order to manipulate the service area. (See *Howard Young Medical Center, Inc.* v. *Shalala*, 207 F.3d 437 (7th Cir. 2000).)

Third, the hospital must provide patient origin data from all other hospitals located within a 35-mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care (§ 412.92(b)(1)(ii)(B)). Again, CMS central office can develop patient origin data for other hospitals within the requesting hospital's service area if the hospital is requesting SCH status based on an examination of Medicare Part A inpatient utilization. In either case, the requesting hospital is required to submit a comprehensive list of hospitals located within a 35-mile radius or, if larger, within its service area. This list will be checked by both the fiscal intermediary and CMS. Again, a requesting hospital cannot argue that a competing hospital should be excluded from the service area based on the existence of specialty services at that hospital if both hospitals are short-term acute care facilities. Distances between all reported hospitals will be checked by both the fiscal intermediary and CMS, through electronic geographic mapping services (such as Yahoo or Mapquest) or by physically driving the distance involved.

In addition, data will be analyzed based on the year for which the hospital requests SCH status. Subsequent hospital mergers or terminations will not be taken into consideration in processing the request. For example, if a hospital requests SCH status using data for FY 1999, and that data show that there is a competing hospital in existence that subsequently closed its doors in FY 2000, the data will be analyzed with the terminated hospital in existence, unless the hospital seeking SCH status applies using later data, such as FY 2001. This principle is consistent with how we analyze wage index data. If a terminated hospital has a viable cost report for the year of wage data that is being analyzed to produce the wage index, its data are included as part of the computation.

We received the following comments on our May 4, 2001 proposed rule and the June 13, 2001 interim final rule with comment period:

Comment: Several commenters were concerned with the following issues related to the qualifying criteria for sole community hospitals: (1) Utilizing TAC worksheets or other data sources in order to develop a base year alternative for a new SCH; (2) determining a service area; (3) recognition of hospital mergers and terminations that influence a hospital seeking SCH status; (4) including competing hospitals within a 35-mile radius of the requesting hospital as opposed to a 35-road-mile distance; (5) obtaining patient origin data from competing hospitals, (6) timeliness of SCH approvals; (7) SCH status for hospitals with fewer than 50 beds; (8) CAHs as like hospitals; (9) the effect of wage index reclassifications on a hospital's SCH status; and (10) the use of affidavits and other certifications in

verifying time and distance when applying for SCH status.

Response: We would like to reiterate that in the proposed rule we were restating historical and current policy and criteria for SCHs. We were not proposing new SCH policies or criteria, or revisions to existing policies or criteria. Rather, we were striving to publish criteria that has been developed over the past several years in one location for the reader's benefit.

First, we appreciate the input concerning a hospital's access to alternative data when a cost report from a prior year may not be readily available. We will take this comment into consideration in working with the fiscal intermediaries in the future to adjust a SCH's payments.

Second, we believe that, using discharge data available on the MedPAR file, we can accurately determine a hospital's service area based on the zip codes that contain the highest number of discharges for that facility and rank those zip codes accordingly. Several commenters suggested that we use patient destination data that are available in some States and, also, that we not be concerned if these data were not available based on a hospital's cost reporting period. As in other aspects of the Medicare program, we must rely on data that are consistent, verifiable by the fiscal intermediaries, and nationally available so that no one hospital or group of hospitals receives a distinct advantage by using an alternative source of data that is not widely available. Therefore, we believe that it is appropriate to determine the hospital's service area based on Medicare discharges.

Third, if a hospital chooses to have a merger recognized in its request for SCH status, or, likewise, a hospital termination, then it is free to wait until its cost report data reflects these changes. Then, CMS will consider the data in light of these facts.

Fourth, we believe it is reasonable to examine a hospital's competitors within a 35-mile radius. Most competing hospitals will not be at the outer limit of the 35-mile radius, and, if these hospitals are not truly competitors, the discharge data will bear out that fact. Also, we examine a hospital's service area based on discharges within zip code areas, and, often, this will exceed a 35-mile radius. Therefore, we believe the 35-mile radius is reasonable.

Fifth, we realize that obtaining patient origin data from competing hospitals may be a difficult proposition, which is why CMS offers to provide this information for the requesting hospital in § 412.92(b)(1)(iii)(A). CMS' data are based on Medicare discharges.

Sixth, approvals of SCH status are effective prospectively. There are several ways in which a hospital may qualify as a SCH, and fiscal intermediaries are required to collect and examine detailed documentation which sometimes requires the assistance of our regional or central office staff. We appreciate the fact that hospitals are concerned that their applications be approved in a timely manner, and we will make every effort to work diligently with our contractors as well as our regional offices to achieve that goal.

Seventh, a commenter suggested that we should be more specific when defining the criteria under which a hospital with fewer than 50 beds could qualify as an SCH at § 412.92(a)(ii). We will take this into consideration as we develop further criteria in the future. In the meantime, we will continue to work closely with our fiscal intermediaries in approving a hospital's SCH status under this provision.

Eighth, we do not consider CAHs like hospitals to be SCHs. CAHs are generally smaller with a very limited length of stay, while SCHs operate as full-service acute-care hospitals.

Ninth, a hospital's status as an SCH is not affected by a wage index reclassification approved by the MGCRB. A hospital's SCH status is affected by an approval for a standardized amount reclassification only, as a reclassification for purposes of a hospital's base payment rate changes its status for all inpatient hospital prospective payment purposes except the wage index.

Finally, hospitals are encouraged to provide as much documentation as possible to assist the fiscal intermediary and CMS in evaluating requests for SCH status. The more complete the documentation, the quicker a decision can be rendered. If a hospital can provide affidavits or other verification of mileage, distances, competing hospital locations, etc., then it is encouraged to do so.

B. Rural Referral Centers (§ 412.96)

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

Section 401 of Public Law 106–113 amended section 1886(d)(8) of the Act by adding subparagraph (E), which creates a mechanism, separate and apart from the MGCRB, permitting an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. The statute directs the Secretary to treat a qualifying hospital as being located in the rural area for purposes of provisions under section 1886(d) of the Act. Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. In addition, one of the criteria under section 1886(d)(8)(E) of the Act is that the hospital would qualify as an SCH or a rural referral center if it were located in a rural area. An SCH would be eligible to be paid on the basis of the higher of its hospital-specific rate or the Federal rate. On the other hand, the only benefit under section 1886(d) of the Act for an urban hospital to become a rural referral center would be waiver of the proximity requirements that are otherwise applicable under the MGCRB process, as set forth in § 412.230(a)(3)(i).

In the August 1, 2000 final rule (65 FR 47089), we stated that we believed Congress contemplated that hospitals might seek to be reclassified as rural under section 1886(d)(8)(E) of the Act in order to become rural referral centers so that the hospitals would be exempt from the MGCRB proximity requirement and could be reclassified by the MGCRB to another urban area. Therefore, in that final rule we sought a policy approach that would appropriately address our concern that these urban to rural redesignations not be utilized inappropriately, and that would benefit hospitals seeking to reclassify under the MGCRB process by achieving rural referral center status. (We became aware of several specific hospitals that were rural referral centers for FY 1991, but subsequently lost their status when the county in which they were located became urban, and had expressed their wish to be redesignated as a rural referral center in order to be eligible to reclassify.) Accordingly, in light of section 1886(d)(8)(E) of the Act and the language in the accompanying Conference Report, effective as of October 1, 2000, hospitals located in what is now an urban area, if they were ever a rural referral center, were reinstated to rural referral center status.

In addition, as discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be classified as a rural referral center for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if its—

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

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value for FY 2002 in the May 4 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2002 were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). Those values were based on discharges occurring during FY 2000 (October 1, 1999 through September 30, 2000) and included bills posted to CMS's records through December 2000. (The proposed rule language erroneously cited the period as FY 1999 (October 1, 1998 through September 30, 1999.)

We proposed that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have a case-mix index value for FY 2000 that is at least—

- 1.3286; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the May 4, 2001 proposed rule at 66 FR 22687.)Based on the latest data available (FY 2000 bills received through March 31, 2001), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have a case-mix index value for FY 2000 that is at least—
- 1.3289; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. The final median case-mix values by region are set forth in the following table:

Region	Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.2381
2. Middle Atlantic (PA, NJ, NY)	1.2319
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3055
4. East North Central (IL, IN, MI, OH, WI)	1.2588
5. East South Central (AL, KY, MS, TN)	1.2530
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1690
7. West South Central (AR, LA, OK, TX)	1.2443
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3275
9. Pacific (AK, CA, HI, OR, WA)	1.2991

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix values from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, in the May 4 proposed rule, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2000 (that is, October 1, 1999 through September 30, 2000). (The proposed rule language erroneously cited the period as FY 1999 (October 1, 1998 through September 30, 1999.) That is the latest year for which we have complete discharge data available.

Therefore, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have as the number of discharges for its cost reporting period that began during FY 2000 a figure that is at least—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 4, 2001 proposed rule at 66 FR 22687.)

Based on the latest discharge data available for FY 2000, the final median number of discharges for urban hospitals by census region areas are as follows:

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,064
2. Middle Atlantic (PA, NJ, NY)	8,488
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA,WV)	8,562
4. East North Central (IL, IN, MI, OH, WI)	7,616
5. East South Central (AL, KY, MS, TN)	6,276
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,210
7. West South Central (AR, LA, OK, TX)	6,196
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,878
9. Pacific (AK, CA, HI, OR, WA)	7,106

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have at least 3,000 discharges for its cost reporting period that began during FY 2000.

We did not receive any comments on the criteria for rural referral centers.

C. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. IME Adjustment Factor Formula Multiplier (Section 111 of Public Law 106–113 and section 302 of Public Law 106–554 and § 412.105(d)(3)).

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a multiplier, which is represented as c, in the following equation: $c \times [(1 + r)^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 302 of Public Law 106–554 amended section 1886(d)(5)(B) of the Act to modify the transition for the IME formula multiplier, or c, that was first established by Public Law 105–33 and revised by Public Law 106–113.

As discussed in the August 1, 2000 final rule and the June 13, 2001 interim final rule with comment period, section 111(a) of Public Law 106–113 revised the formula multiplier for discharges occurring during FY 2001 (established under Public Law 105–33 at 1.6) to 1.54. However, section 302(b) of Public Law 106–554 provides a special payment rule which states that, for discharges occurring on or after April 1, 2001 and before October 1, 2001, IME payments are to be made as if 'c' equaled 1.66, rather than 1.54. The multiplier of 1.54 for the first 6 months of FY 2001 represents a 6.25 percent increase in the level of the IME adjustment for every 10 percent increase in the resident-to-bed ratio, and the multiplier for the second 6 months of FY 2001 represents a 6.75 percent increase in the level of the IME adjustment for every 10 percent increase in the resident-to-bed ratio. This results in an aggregate 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio for FY 2001. Section 547(a)(2) of Public Law 106–554 provides further clarification that these payment increases will not apply to discharges occurring after FY 2001 and will not be taken into account in calculating the payment amounts applicable for discharges occurring after FY 2001. In the June 13 interim final rule, we revised § 412.105(d)(3)(v) to reflect the additional payment provided for discharges occurring during FY 2001 under section 302(b) of Public Law 106–554.

As discussed in the May 4, 2001 proposed rule, section 302(a) of Public Law 106–554 provides that, for discharges occurring during FY 2002, the formula multiplier is 1.6. For discharges occurring during FY 2003 and thereafter, the formula multiplier is 1.35. As explained above, section 302(b) of Public Law 106–554 provides for a special payment rule which states that, for discharges occurring on or after April 1, 2001 and before October 1, 2001, IME payments are to be made as if ''c'' equaled 1.66 rather than 1.54. The multiplier of 1.6 for FY 2002 represents a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio. The multiplier for FY 2003 and thereafter (1.35) represents a 5.5-percent increase for every 10-percent increase in the resident-to-bed ratio. In the May 4 proposed rule, we proposed to revise § 412.105(d)(3)(vi) to reflect the change in the formula multiplier for FY 2002 to 1.6 as made by section 302(a) of Public Law 106–554 for discharges occurring during FY 2002. We also proposed to add § 412.105(d)(3)(vii) to incorporate the formula multiplier of 1.35 for discharges occurring on or after October 1, 2002.

We did not receive any comments on the IME formula provisions of the June 13 interim final rule with comment period or the proposed amendments under the May 4 proposed rule. Therefore, we are adopting both changes to § 412.105(d)(3) as final without change.

2. Resident-to-Bed Ratio Cap (§ 412.105(a)(1))

In the May 4, 2001 proposed rule, we indicated that it had come to our attention that there is some misunderstanding about § 412.105(a)(1) regarding the determination of the resident-to-bed ratio that is used in calculating the IME adjustment. Section 4621(b)(1) of Public Law 105–33 amended section 1886(d)(5)(B) of the Act by adding a new clause (vi) to provide that, effective for cost reporting periods beginning on or after October 1, 1997, the resident-to-bed ratio may not exceed the ratio calculated during the prior cost reporting period (after accounting for the cap on the hospital's number of full-time equivalent (FTE) residents). We implemented this policy in the August 29, 1997 final rule with comment period (62 FR 46003) and the May 12, 1998 final rule (63 FR 26323) under regulations at § 412.105(a)(1). Existing § 412.105(a)(1) specifies that ''[e]xcept for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or

after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period.'' In the May 4 proposed rule, we proposed to clarify § 412.105(a)(1) to add a provision that this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period *after accounting for the cap on the number of FTE residents.*

In general, the resident-to-bed ratio from the prior cost reporting period, which is to be used as the cap on the resident-to-bed ratio for the current payment cost reporting period, should only include an FTE count subject to the FTE cap on the number of allopathic and osteopathic residents, but is *not* subject to the rolling average. (An explanation of rolling average appears in section IV.H.3. of this preamble.)

The following illustrates the steps for determining the resident-to-bed ratio for the current payment year cost reporting period and the cap on the resident-to-bed ratio:

Current payment year cost reporting period resident-to-bed ratio:

Step 1. Determine the hospital's number of FTE residents in the current payment year cost reporting period.

Step 2. Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap (§ 412.105(f)(1)(iv)). If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the number of FTEs in the FTE cap. Add any dental and podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count.

Step 3. Determine the 3-year rolling average of the FTE residents using the FTEs from the current payment year cost reporting period and the prior two cost reporting periods (subject to the FTE cap in each cost reporting period). (Include podiatry and dental residents, and exclude residents in new programs in accordance with § 412.105(f)(1)(iv) and revised (f)(1)(v). Residents in new programs are added to the quotient of the rolling average.)

Step 4. Determine the hospital's number of beds (see § 412.105(b)) in the current payment year cost reporting period.

Step 5. Determine the ratio of the number of FTEs from step 3 to the number of beds from step 4. The lower of this resident-to-bed ratio or the resident-to-bed ratio cap (calculated below) from the immediately preceding cost reporting period is used to calculate the hospital's IME adjustment factor for the current payment year cost reporting period.

Resident-to-bed ratio cap:

Step 1. Determine the hospital's number of FTE residents in its cost reporting period that immediately precedes the current payment year cost reporting period.

Step 2. Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap. If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the number of FTEs in the FTE cap. Add any dental and podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count. (If there is an increase in the number of FTEs in the current payment year cost reporting period due to a new program or an affiliation agreement, these FTEs are added to FTEs in the preceding cost reporting period after applying the FTE cap.)

Step 3. Determine the hospital's number of beds (§ 412.105(b)) in its cost reporting period that immediately precedes the current payment year cost reporting period.

Step 4. Determine the ratio of the number of FTEs in step 2 to the number of beds in step 3. This ratio is the resident-to-bed ratio cap for the current payment year cost reporting period.

Step 5. Compare the resident-to-bed ratio cap in step 4 to the resident-to-bed ratio in the current payment year cost reporting period. The lower of the resident-to-bed ratio from the current payment year cost reporting period or the resident-to-bed ratio cap from the immediately preceding cost reporting period is used to calculate the hospital's IME adjustment factor for the current payment year cost reporting period.

We note that the resident-to-bed ratio cap is a cap on the resident-to-bed ratio calculated for all residents, including allopathic, osteopathic, dental, and podiatry residents (63 FR 26324, May 12, 1998). However, as described in existing § 412.105(a)(1), the resident-to-bed ratio cap may be adjusted to reflect an increase in the current cost reporting period's resident-to-bed ratio due to residents in a new GME program or an affiliation agreement. While an exception does not apply if the resident-to-bed ratio increases because of an increase in the number of podiatry or dentistry residents or because of a change in the number of beds, the ratio could increase after a one-year delay. An increase in the current cost reporting period's ratio (while subject to the FTE cap on the overall number of allopathic and osteopathic residents) thereby establishes a higher cap for the following cost reporting period.

The following is an example of the application of the cap on the resident-to-bed ratio:

Example—Part 1:

- Assume Hospital A has 50 FTEs in its cost reporting period ending September 30, 1996, thereby establishing an IME FTE resident cap of 50 FTEs.
- In its cost reporting period of October 1, 1996 to September 30, 1997 (the prior year), it has 50 FTEs and 200 beds, so that its resident-to-bed ratio for this period is 50/200 = .25.
- In the (current year) cost reporting period of October 1, 1997 to September 30, 1998 (the first cost reporting period in which the FTE resident cap, the resident-to-bed ratio cap, and the rolling average apply), Hospital A has 50 FTEs and 200 beds.
- Hospital A's FTEs do not exceed its FTE cap, so its current number of FTEs (50) is used to calculate the 2-year rolling average: (50 + 50)/2 = 50.
- The result of the rolling average is used as the numerator of the resident-to-bed ratio. Thus, the resident-to-bed ratio is 50/200 = .25.
- .25 is compared to the resident-to-bed ratio from the prior period of October 1, 1996 to September 30, 1997. Because the FTE resident cap and the rolling average were not yet effective in the period of October 1, 1996 to September 30, 1997, that period s resident-to-bed ratio does not have to be recalculated to account for the FTE resident cap. Accordingly, the resident-to-bed ratio cap for October 1, 1997 to September 30, 1998 is .25.
- Because the resident-to-bed ratio does not exceed the prior year ratio, Hospital A would use the resident-to-bed ratio of .25 to determine the IME adjustment in its cost reporting period of October 1, 1997 to September 30, 1998.

Example—Part 2:

- In the (current year) cost reporting period of October 1, 1998 to September 30, 1999, Hospital A adds 1 podiatric and 1 dental resident, so that it has a total of 52 FTEs and 200 beds. Since the FTE resident cap only includes allopathic and osteopathic residents, Hospital A has not exceeded its FTE resident cap with the addition of a podiatric and a dental resident.
- Accordingly, the (now) 3-year rolling average would be (52 + 50 + 50)/3 = 50.67.
- 50.67 is used in the numerator of the current payment year's resident-to-bed ratio, so that the resident-to-bed ratio is 50.67/200 = .253.
- .253 is compared to the resident-to-bed ratio from the prior year's cost reporting period of October 1, 1997 to September 30, 1998 that is recalculated to account for the FTE resident cap. Because Hospital A did not exceed its FTE resident cap of 50 FTEs in this period of October 1, 1997 to September 30, 1998, the recalculated resident-to-bed ratio would be 50/200 = .25.
- Compare the current year resident-to-bed ratio (.253) to the resident-to-bed ratio cap (.25); .253 *does exceed* .25.
- Therefore, the resident-to-bed ratio in the period of October 1, 1998 to September 30, 1999 is capped at .25, which is to be used in calculating Hospital A s IME adjustment for October 1, 1998 to September 30, 1999.

Example—Part 3:

- In the cost reporting period of October 1, 1999 to September 30, 2000, Hospital A adds

2 internal medicine residents so that it has a total of 54 FTEs and 200 beds. While podiatric and dental residents are not included in the FTE resident cap, internal medicine residents are included. Hospital A has exceeded its IME FTE resident cap of 50 by 2 FTEs. Thus, 2 FTEs are excluded from the FTE count.

- Accordingly, the rolling average would be (52 + 52 + 50)/3 = 51.33.
- 51.33 is used in the numerator of the resident-to-bed ratio, so that the resident-to-bed ratio is 51.33/200 = .257.
- .257 is compared to the resident-to-bed ratio from October 1, 1998 to September 30, 1999 that is recalculated to only account for the FTE resident cap. The recalculated resident-to-bed ratio would be 50 allopathic or osteopathic FTEs plus 1 podiatric and 1 dental resident, which is 52/200 = .26.
- .26 is the resident-to-bed ratio cap for October 1, 1999 to September 30, 2000. .257 *does not exceed* .26.
- Therefore, the resident-to-bed ratio in the period of October 1, 1998 to September 30, 1999 is .257, which is to be used in calculating this period s IME adjustment.

If a hospital starts a new GME program, the adjustment to the resident-to-bed ratio cap applies for the period of years equal to the minimum accredited length for each new program started. (For example, for a new internal medicine program, the period of years equals 3; for a new surgery program, the period of years equals 5.) Within these program years, the number of new FTE residents in the current cost reporting period is added to the FTE resident count used in the numerator of the resident-to-bed ratio from the previous cost reporting period. The lower of the resident-to-bed ratio from the current cost reporting period or the adjusted resident-to-bed ratio from the preceding cost reporting period is used to calculate the hospital's IME adjustment for the current cost reporting period. If a hospital subsequently continues to expand its program, the numerator of the resident-to-bed ratio from the preceding cost reporting period would not be adjusted to reflect these additional residents. However, an increase in the ratio of the current cost reporting period would establish a higher cap for the following cost reporting period.

We also proposed to add a provision that the exception for new programs described in § 412.105(f)(1)(vii) applies for the period of years equal to the minimum accredited length for each new program.

Similarly, if a hospital increases the number of FTE residents in the current cost reporting period because of an affiliation agreement, the number of additional FTEs is added to the FTE resident count used in the numerator of the resident-to-bed ratio from the previous cost reporting period. The lower of the resident-to-bed ratio from the current cost reporting period or the adjusted resident-to-bed ratio from the preceding cost reporting period is used to calculate the hospital's IME adjustment for the current cost reporting period.

Comment: Several commenters addressed our clarifications to the regulations at § 412.105(a)(1) regarding the cap on the resident-to-bed ratio. One commenter stated that the explanation in the proposed rule regarding the resident-to-bed ratio was thorough. Another commenter expressed appreciation for the inclusion of examples in the proposed rule's preamble. One commenter noted that, in the proposed rule under step 2 of the example of the calculation of the resident-to-bed ratio cap, we indicate that the lesser of the prior year FTEs or the FTE cap is used in the numerator of the resident-to-bed ratio. The commenter noted that we do not specify that, while the FTE cap only applies to allopathic and osteopathic FTEs, dentistry and podiatry FTEs should be included in the numerator of the resident-to-bed ratio. The commenter asked that we specify that the prior year podiatry and dentistry FTEs must be added to the FTE count used in the resident-to-bed ratio after the FTE cap has been applied.

Response: We agree with the commenter concerning the inclusion of dental and podiatry FTEs in step 2, and we have clarified the language in step 2 of the examples of both the current year resident-to-bed ratio and the resident-to-bed ratio cap calculation in the preamble of this final rule. Specifically, we state, ''Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap. If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the FTE cap. Add any dental or podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count.'' Furthermore, we are revising the proposed changes to the regulations text at § 412.105(a)(1) to state that ''. . . this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents. . . .''

Comment: One commenter noted that, in clarifying the regulations at § 412.105(a)(1) regarding the resident-to-bed ratio cap, we added that the exception to the resident-to-bed ratio cap ''. . . for new programs . . . applies for the period of years equal to the minimum accredited length *for that type of program*'' (emphasis added). The commenter asked how we would apply the exception to the resident-to-bed ratio cap in a situation where a hospital has started several new programs with varying minimum accredited lengths.

Response: The exception at proposed § 412.105(a)(1) for new programs allows a hospital to add a full complement of residents and complete the initial cycle of a program before residents in the new programs are included in the application of the resident-to-bed ratio cap. In a situation where a hospital has started several new programs under § 412.105(f)(1)(vii), we would apply the exception to the resident-to-bed ratio cap to each new program individually based on each program's minimum accredited length. For example, if a hospital simultaneously starts a new internal medicine program (which has a minimum accredited length of 3 years) and an anesthesiology program (which has a minimum accredited length of 4 years), the FTE residents in the new internal medicine program will be subject to the resident-to-bed ratio cap in the fourth program year of the internal medicine program, while the anesthesiology FTE residents would still be excluded from the resident-to-bed ratio cap in the fourth program year of the anesthesiology programs. However, in subsequent program years, the anesthesiology FTE residents would be subject to the resident-to-bed ratio cap, as well.

The rules regarding the exception from the rolling average calculation for IME are the same for direct GME. The proposed revised regulations at § 412.105(f)(1)(v) and § 413.86(g)(5) in the May 4, 2001 proposed rule state that FTE residents in a new program are excluded from the rolling average calculation for the period of years equal to the minimum accredited length for the type of program. In this final rule, we are revising the regulations regarding the exceptions to the resident-to-bed ratio cap and the rolling average calculation for both IME and direct GME to clarify that these exceptions apply to each new program individually for which the FTE cap may be adjusted based on each program's minimum accredited length (§ 412.105(a)(1), 412.105(f)(1)(v), and 413.86(g)(5)(v)).

Comment: One commenter asserted that, in the proposed rule, it is inconsistent to account for both the FTE cap and the rolling average count of residents in the current year resident-to-bed ratio, but account for only the FTE cap in the resident-to-bed ratio cap

(which is the prior year's ratio). The commenter stated that their willingness to support the proposed rule depended on whether the residency program is increasing or decreasing its FTEs every year.

Response: Section 1886(d)(5)(B)(v)(I) of the Act, as amended by Public Law 105–33, states that the resident-to-bed ratio ''may not exceed the ratio of the number of interns and residents, *subject to the limit under clause (v),* with respect to the hospital for its most recent cost reporting period to the hospital's available beds . . . during that cost reporting period . . .'' (emphasis added). Clause (v) is the FTE cap requirement; the statute does not specify clause (vi)(II), which is the rolling average requirement, in relation to the resident-to-bed ratio cap. Accordingly, the implementing regulations require that the resident-to-bed ratio cap should only account for the cap on the number of FTEs.

In addition, we note that the commenter is mistaken in indicating that the rules regarding the determination of the resident-to-bed ratio and the resident-to-bed ratio cap are proposed rules. These rules have been in place based on the statute since the effective date of Public Law 105–33. We simply took the opportunity in the proposed rule published on May 4, 2001 to further clarify our existing policy because we realized that there was some confusion surrounding these rules.

Comment: One commenter noted that, since under the provisions of § 413.86(g)(6)(i), the FTE cap for new programs is established based on the number of residents in the third year of the first program's existence, it follows that the FTE cap on the residents in the new programs is effective in the fourth program year. The commenter asked if the application of the cap is delayed until the expiration of the minimum accredited length of the new programs.

Response: The application of the FTE adjusted caps for new programs under § 413.86(g)(6)(i) and (g)(6)(ii) are not delayed until the expiration of the minimum accredited length of the new programs. Only the application of the resident-to-bed ratio cap for IME and the rolling average for both IME and direct GME are dependent upon the minimum accredited length of each new program. The regulations at § 413.86(g)(6)(i) state that the cap for new programs will be adjusted based on ''the product of the highest number of residents in any program year *during the third year of the first* program's existence for *all* new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program'' (*emphasis added*). In general, when a hospital qualifies for a cap adjustment under § 413.86(g)(6)(i), the hospital has three years from the time that a resident first begins training in the first new program to establish its FTE cap. The first day of the fourth program year, the FTE cap on that first program, and any other programs that may have been started within the initial three years of that first program, is permanently established and takes effect.

For example, if a hospital that qualifies for a cap adjustment under § 413.86(g)(6)(i) starts a newly accredited dermatology program on July 1, 2001, and then starts a newly accredited anesthesiology program on July 1, 2002, the cap for both programs, and for the hospital as a whole, will be adjusted as of July 1, 2004, the first day of the fourth program year of dermatology, which is the first program that the hospital started. The hospital's cap will be based on the sum of: (a) The product of the highest number of residents in either PGY1, PGY2, or PGY3 in the third year of the dermatology program and 4 years (the minimum accredited length of dermatology); and (b) the product of the highest number of residents in either PGY1 or PGY2 for the anesthesiology program and 4 years (the minimum accredited length for anesthesiology). Any programs begun after the first program's start date but before the fourth program year of the first program will not have a full 3 years before the hospital's cap is permanently adjusted.

The rules under § 413.86(g)(6)(ii) differ for hospitals that qualify for an FTE cap adjustment for new programs started on or after January 1, 1995 and on or before August 5, 1997. Section 413.86(g)(6)(ii) states that the FTE cap adjustment is ''based on the product of the highest number of residents in any program year *during the third year of the newly established program* and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program'' (emphasis added). In contrast to hospitals that qualify for a cap adjustment under § 413.86(g)(6)(i), where the cap for the hospital takes effect for *all* programs in the fourth program year of the first program that was started by the hospital, hospitals that qualify for an FTE cap adjustment under § 413.86(g)(6)(ii) have a full 3 years to grow *each* new program, as long as those programs all started training residents or received accreditation between January 1, 1995 and on or before August 5, 1997. The adjustment to the cap for each of those new programs would be applied individually, beginning with the *first day of the fourth program year of each new program.* (We note that rural hospitals that qualify for a cap adjustment under § 413.86(g)(6)(iii) may receive an FTE cap adjustment in the same manner as hospitals that qualify for the cap adjustment under § 413.86(g)(6)(ii), except that rural hospitals may receive this adjustment for programs started after August 5, 1997).

For example, assume a hospital that qualifies for a cap adjustment under § 413.86(g)(6)(ii) started a newly accredited internal medicine program on July 1, 1996, and a newly accredited dermatology program on July 1, 1997. The adjustment to the hospital's FTE cap because of the internal medicine program was effective July 1, 1999 (the first day of the fourth program year of internal medicine), and the cap adjustment resulting from the dermatology program was effective July 1, 2000 (the first day of the fourth program year for dermatology). The hospital's ultimate FTE cap is the sum of the FTE cap based on FTEs in the hospital's most recent cost reporting period ending on or before December 31, 1996, and the cap adjustments for the internal medicine and dermatology programs. (We note that since the internal medicine program began in 1996, depending on the hospital's cost reporting period, a portion of those FTEs may have already been included in the hospital's FTE cap. That portion that was included in the FTE cap must be subtracted from the cap adjustment that was calculated for the internal medicine program to avoid any double counting of the FTEs). The hospital's adjusted cap will be based on the sum of: (a) the product of the highest number of internal medicine residents in either PGY1, PGY2, or PGY3 in the third year of the internal medicine program and three (the minimum accredited length of internal medicine); and (b) the product of the highest number of dermatology residents in either PGY1, PGY2, or PGY3 for the dermatology program and four (the minimum accredited length for dermatology).

In summary, we reiterate that the application of the FTE cap adjustments for new programs is *not* delayed until the program year in which the minimum accredited length of each program expires. This would even apply to a new program with a minimum accredited length that exceeds 3 years. The FTE cap adjustment takes effect on the first day of the fourth program year of the first new program that was started

by hospitals qualifying for a cap adjustment under § 413.86(g)(6)(i). For hospitals qualifying for a cap adjustment under § 413.86(g)(6)(ii) and (g)(6)(iii), the cap adjustments take effect on the first day of the fourth program year of each new program. However, the application of the resident-to-bed ratio cap for IME and the rolling average for both IME and direct GME are dependent upon the minimum accredited length of each new program.

Comment: With regard to the counting of residents for IME payment purposes in nonhospital sites, one commenter stated that although time spent in nonhospital sites may be included in the IME FTE count effective for discharges occurring on or after October 1, 1997, the application of the 1996 FTE cap effectively disallows the current year's FTEs training in the nonhospital site, because the 1996 FTE cap was based on residents training only in the hospital. The commenter added that only those hospitals that are in a position to elect a Medicare affiliation agreement are able to ''circumvent'' the 1996 FTE limit; those that cannot are ''penalized.'' The commenter further stated that the regulatory intent of allowing nonhospital training time to be counted is not fully met by having only certain hospitals able to affiliate. The commenter recommended that we should allow hospitals to recalculate the 1996 IME FTE cap to include those FTEs training in nonhospital sites, so that hospitals will effectively be able to count residents currently training in nonhospital sites for IME purposes.

Response: The commenter is addressing a provision in Public Law 105–33 that was implemented in regulations at § 412.105(f)(1)(ii)(C). We did not propose any substantive changes to this policy; we simply were correcting an oversight in the regulations text for IME. (Comments on regulations implementing this provision were addressed in the May 12, 1998 final rule (63 FR 26323) and the July 31, 1998 final rule (63 FR 40954).)

3. Conforming Changes (§ 412.105(f)(1)(ii)(C) and (f)(1)(v))

In the August 29, 1997 final rule with comment period (62 FR 46003), the May 12, 1998 final rule (63 FR 26323), and the July 31, 1998 final rule (63 FR 40986), to implement the provisions of Public Law 105–33, we set forth certain policies that affected payment for both direct and indirect GME. Some of these policies related to the FTE cap on allopathic and osteopathic residents, the rolling average, and payment for residents training in nonhospital settings. In the May 4 proposed rule, we indicated that when we amended the regulations under § 413.86 for direct GME, we inadvertently did not make certain conforming changes in § 412.105 for IME. We proposed to make the following conforming changes:

- To revise § 412.105(f)(1)(ii)(C) to specify that, effective for discharges occurring on or after October 1, 1997, the time residents spend training in a nonhospital setting in patient care activities under an approved medical residency training program may be counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(3) or § 413.86(f)(4), as applicable, are met.
- To revise § 412.105(f)(1)(v) to specify that residents in new residency programs are not included in the rolling average for a period of years equal to the minimum accredited length for the type of program.

In addition, we proposed to revise § 412.105(f)(1)(ix) to specify, for IME purposes, a temporary adjustment to a hospital's FTE cap to reflect residents added because of another hospital's closure of its medical residency program (to conform to the May 4, 2001 proposed change for GME discussed in section IV.H.5. of this preamble).

We did not receive any comments on these conforming changes and are adopting them as final.

D. Payments to Disproportionate Share Hospitals (DSH) (Sections 211 and 303 of Public Law 106–554 and § 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that serve a disproportionate number of low-income patients (the DSH patient percentage as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Hospitals that meet the DSH patient percentage criteria are entitled to the DSH payment adjustment.

1. Qualifying Thresholds for DSHs

In the June 13, 2001 interim final rule with comment period, we discussed the provisions of section 1886(d)(5)(F)(v) of the Act, as it existed prior to enactment of Public Law 106–554 and under § 412.106(c) of the existing regulations, which provided that a hospital qualified for DSH if the hospital had a DSH patient percentage equal to:

- At least 15 percent for an urban hospital with 100 or more beds or a rural hospital with 500 or more beds;
- At least 40 percent for an urban hospital with fewer than 100 beds;
- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as an SCH;
- At least 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or which is classified as an SCH; or
- The hospital has 100 or more beds, is located in an urban area, and receives more than 30 percent of its net inpatient revenues from State and local government sources for the care of indigent patients not eligible for Medicare or Medicaid.

Section 211(a) of Public Law 106–554 amended section 1886(d)(5)(F)(v) to provide that, beginning with discharges occurring on or after April 1, 2001, the qualifying threshold is reduced to 15 percent for all hospitals. Therefore, in the June 13 interim final rule, we revised § 412.106(c) to reflect the change in DSH qualifying threshold percentages.

Comment: Several commenters responded on the subject of the calculation of the DSH payment adjustment. These commenters were concerned about how to apply the threshold changes as of April 1, 2000. They were also concerned about counting days in the calculation when a stay crosses over two cost reporting periods. Finally, these commenters were concerned about counting section 1115 expansion waiver days in the DSH payment adjustment calculation.

Response: Section 211(a) of Public Law 106–554 amended section 1886(d)(5)(F) of the Act to change the qualifying thresholds for the DSH payment adjustment to 15 percent for all hospital types, effective with discharges occurring on or after April 1, 2001. This means that the legislation is effective with discharges occurring on or after April 1, 2001, but not before. Therefore, fiscal intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001, by applying the DSH patient percentage in the formula to each separate period. Days are counted based on the date of discharge. In other words, a hospital stay would be counted in the cost reporting year during which the patient was discharged.

Finally, counting section 1115 expansion waiver days in the DSH payment adjustment calculation was discussed in the August 1, 2000 **Federal Register** (65 FR 47086). This policy became effective for discharges occurring on or after January 20, 2000. Therefore, it is possible that a hospital will qualify for DSH payments as of January 20, 2000, whereas it did not qualify before January 20, 2000, and it should be paid accordingly. In other words, a hospital in that situation would receive Medicare DSH payments beginning January 20, 2000.

2. Calculation of the DSH Payment Adjustment

Section 211(b) of Public Law 106–554 further amended section 1886(d)(5)(F) to revise the calculation of the DSH payment adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of the Act. In the June 13 interim final rule with comment period, we discussed these adjustments, which are effective for discharges occurring on or after April 1, 2001, as follows:

• Urban hospitals with fewer than 100 beds and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage − 15) (.65) + 2.5.

• Urban hospitals with fewer than 100 beds and whose DSH patient percentage is equal to or greater than 19.3 percent receive a flat add-on of 5.25 percent.

• Rural hospitals that are both rural referral centers and SCHs receive the DSH payment adjustment determined using the higher of the SCH adjustment or the rural referral center adjustment.

• Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage − 15) (.65) + 2.5.

• Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 19.3 percent and less than 30 percent receive a flat add-on of 5.25 percent.

• Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 30 percent receive 10 percent.

• Rural referral centers whose DSH patient percentage is greater than or equal to 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage − 15) (.65) + 2.5.

• Rural referral centers whose DSH patient percentage is equal to or greater than 19.3 percent but less than 30 percent receive a flat add-on of 5.25 percent.

• Rural referral centers whose DSH patient percentage is equal to or greater than 30 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage—30) (.6) + 5.25.

• Rural hospitals with fewer than 500 beds and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment using the following formula:

(DSH patient percentage—15) (.65) + 2.5.

• Rural hospitals with fewer than 500 beds and whose DSH patient percentage is equal to or greater than 19.3 percent receive a flat add-on of 5.25 percent.

If we calcqulate DSH patient percentages to the hundredth place (our current practice), these payment formulas result in an anomaly for some DSH patient percentages just below 19.3 percent (but greater than 19.2 percent). That is, as the percentage values approach 19.3, the DSH payment adjustment resulting from the formula exceeds 5.25 percent. This would result in a higher DSH payment adjustment for DSH patient percentages just below 19.3 than for percentages of 19.3 and above. We stated in the June 13 interim final rule that, because we believe it would be contrary to the Congress' intent for hospitals with a DSH patient percentage of less than 19.3 percent to receive a greater payment than those hospitals of the same class that have a DSH patient percentage of 19.3 or greater, we were implementing this provision so that, for DSH patient percentages below 19.3 for affected hospitals, the DSH payment adjustment will not exceed 5.25 percent.

In the June 13 interim final rule with comment period, we revised § 412.106(d) to reflect the changes in the disproportionate share adjustment.

3. Percentage Reduction to the DSH Payment Adjustment

Section 1886(d)(5)(F)(ix) of the Act, as amended by section 112 of Public Law 106–113, specifies a percentage reduction in the payments a hospital would otherwise receive under the DSH payment adjustment formula. Prior to enactment of section 303 of Public Law 106–554, the reduction percentages were as follows: 3 percent for FY 2001, 4 percent for FY 2002, and 0 percent for FY 2003 and each subsequent fiscal year.

Section 303 of Public Law 106–554 revised the amount of the percent reductions to 2 percent for discharges occurring in FY 2001, and to 3 percent for discharges occurring in FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. Section 303 of Public Law 106–554 contains a special rule for FY 2001: For discharges occurring on or after October 1, 2000 and before April 1, 2001, the reduction is to be 3 percent, and for discharges occurring on or after April 1, 2001 and before October 1, 2001, the reduction is to be 1 percent. Changes made by section 303 with respect to FY 2001 discharges were implemented in the June 13, 2001 interim final rule with comment period.

We are adopting as final the revisions to § 412.106(e) to reflect the change in the percentages made by section 303 of Public Law 106–554 that were included in the May 4, 2001 proposed rule and in the June 13, 2001 interim final rule with comment period. We also are making a technical change in the heading of paragraph (e).

E. Medicare-Dependent, Small Rural Hospitals (Section 404 of Public Law 106–113 and section 212 of Public Law 106–554 and 42 CFR 412.90(j) and 412.108)

Section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239) added section 1886(d)(5)(G) to the Act and created the category of Medicare-dependent, small rural hospital (MDH) that are eligible for a special payment adjustment under the hospital inpatient prospective payment system. Section 1886(d)(5)(G) of the Act define an MDH as any hospital that meets all of the following criteria:

• The hospital is located in a rural area.

• The hospital has 100 or fewer beds.

• The hospital is not classified as an SCH (as defined at § 412.92).

• In the hospital's cost reporting period that began during FY 1987, not less than 60 percent of its inpatient days or discharges were attributable to inpatients entitled to Medicare Part A benefits. If the cost reporting period is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(For a more detailed discussion, see the April 20, 1990 **Federal Register** (55 FR 15154)).

As provided by the law, MDHs were eligible for a special payment adjustment under the prospective payment system, effective for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to SCHs, that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

• The national Federal rate applicable to the hospital.

• The updated hospital-specific rate using FY 1982 cost per discharge.

• The updated hospital-specific rate using FY 1987 cost per discharge.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) extended the MDH provision through FY 1994 and provided that, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which the hospital-specific rate exceeded the Federal rate.

Section 4204(a)(3) of Public Law 105–33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise the qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106–113 extended the MDH provision to discharges occurring on or after October 1, 2002 and before October 1, 2006. In the August 1, 2000 interim final rule with comment period, we revised §§ 412.90(j) and 412.108 to reflect the extension of the MDH program through FY 2006.

As specified in the June 13, 2001 interim final rule with comment period, section 212 of Public Law 106–554 provided that, effective with cost reporting periods beginning on or after April 1, 2001, hospitals have the option to base MDH eligibility on two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, rather than on the cost reporting period that began during FY 1987. According to section 212, the criteria for at least 60 percent Medicare utilization will be met if in at least ''2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report'', at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits.

Hospitals that qualify under this provision are subject to the other provisions already in place for MDHs, that is, the payment methodology as defined in § 412.108(c) and the volume decrease provision as defined in § 412.108(d).

A hospital must notify its fiscal intermediary to be considered for MDH status under this new provision. Any hospital that believes it meets the criteria to qualify as an MDH, based on at least two of its three most recently settled cost reports, must submit a written request to its intermediary. The hospital's request must be submitted within 180 days from the date of the notice of amount of program reimbursement for the cost reporting period in question. The intermediary will make its determination and notify the hospital within 180 days from the date it receives the hospital's request and all of the required documentation.

In the June 13 interim final rule with comment period, we revised § 412.108(a)(1)(iii) to reflect the additional option provided by section 212 of Public Law 106–554.

We received one comment on the proposed regulation change.

Comment: One commenter representing a state hospital association expressed concern regarding the MDH qualifying process outlined in the interim final rule. The commenter questioned the timing of the process, especially that the hospital would be required to apply within 180 days from the date of the notice of program reimbursement and that the fiscal intermediary would have up to 180 days in which to make its decision. The commenter believed that this would not allow hospitals to qualify by the first cost reporting period beginning on or after the April 1, 2001, effective date of the new provision. The commenter also believed that this process would result in a lengthy period of time, perhaps 2–4 years while the cost report settlement and this process plays out. The commenter also believed the determination of whether or not a hospital meets the requirements to become an MDH under this new provision should be handled in manner consistent with that already in place. That is, fiscal intermediaries should automatically determine, using the cost report information they have, whether or not any additional hospitals would now qualify as an MDH under this new criteria, rather than putting the burden on the hospitals to apply for MDH status. The commenter also stated that the fiscal intermediaries require instruction regarding the calculation of the payment rates in order to determine which would most benefit the MDHs. The commenter also believed that the impact analysis understates the number of newly eligible hospitals under the new MDH provision.

Response: We disagree with the commenter that the process for approval of new MDHs could take as long as 2 to 4 years. We do agree with this commenter that hospitals' requests for consideration under this provision need not be limited to requests submitted within 180 days of the issuance of a notice of amount of program reimbursement, and we are deleting this requirement from § 412.108(b). This will eliminate any unintended delay in the time when hospitals could request MDH status. Therefore, hospitals are free to request MDH status at any time. We also are revising the time provided for fiscal intermediaries to make their determination, from 180 days to 90 days. We believe this will provide sufficient time for review while being responsive to the commenter's concern that the process not be too lengthy. Similar to the approval period for SCHs as described above, MDH status and the associated payment adjustment are effective 30 days after written notification to the MDH.

We believe it is most appropriate, and consistent with procedures for SCH and rural referral center designation, to require hospitals to request consideration as a MDH, rather than placing this requirement with the fiscal intermediaries. We will further clarify the MDH policy and process, including the change noted above, through future Program Memoranda.

With respect to the commenter's concern that our impact analysis underestimates the number of newly eligible hospitals under the new provision, we noted in the June 13, 2001 interim final rule with comment period that our most recent data available were 1998, and we were, therefore, unable to estimate the impacts using more recent data. Therefore, the actual impact of this provision may be different as the fiscal intermediaries evaluated hospitals' requests using more recent data.

F. Reclassification of Certain Urban Hospitals as Rural Hospitals (Sections 401(a) and (b) of Public Law 106–113 and 42 CFR 412.63(b), 412.90(e), 412.102, and 412.103)

1. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals

Under Medicare law, the location of a hospital can affect its payment methodology as well as whether the facility qualifies for special treatment both for operating and for capital payments. Whether a facility is situated in an urban or a rural area will, for example, affect payments based on the wage index values and Federal standardized amounts specific to the area. Similarly, the percentage increase in payments made to hospitals that treat a disproportionate share of low-income patients is based, in part, on its urban/rural status, as are determinations regarding a hospital's qualification as an SCH, rural referral center, critical access hospital (CAH), or other special category of facility. Section 1886(d)(2)(D) of the Act defines an ''urban area'' as an area within a MSA as defined by the Office of Management and Budget. The same

provision defines a ''large urban area,'' with respect to any fiscal year, as an urban area that the Secretary determines (in the publications described in section 1886(e)(5) of the Act before the fiscal year) has a population of more than 1 million as determined based on the most recent available published Census Bureau data. Section 1886(d)(2)(D) of the Act further defines a ''rural area'' as an area that is outside of a ''large'' urban area or ''other'' urban area. Since FY 1995, the average standardized amount for hospitals located in rural areas and ''other'' urban areas has been equal, as provided for in section 1886(b)(3)(B)(i)(X) of the Act.

Several provisions of the Act provide procedures under which a hospital can apply for reclassification from one geographic area to another. Section 1886(d)(8)(B) of the Act, which provides that if certain conditions are met, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute. Also, section 1886(d)(10) of the Act established the MGCRB to permit hospitals that are disadvantaged by their geographic classification to obtain a more appropriate classification to the area with which they have the most economic interaction.

In the August 1, 2000 interim final rule with comment period (65 FR 47029), we implemented section 401(a) of Public Law 106–113. Section 401(a) of Public Law 106–113, which amended section 1886(d)(8) by adding a new paragraph (E), directs the Secretary to treat any subsection (d) hospital located in an urban area as being located in the rural area of the State in which the hospital is located if the hospital files an application (in the form and manner determined by the Secretary) and meets one of the following criteria:

- The hospital is located in a rural census tract of an MSA (as determined under the most recent modification of the Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992 (57 FR 6725));
- The hospital is located in an area designated by any law or regulation of the State as a rural area (or is designated by the State as a rural hospital);
- The hospital would qualify as a rural referral center, or as an SCH if the hospital were located in a rural area; or
- The hospital meets any other criteria specified by the Secretary.

The statutory effective date of this provision is January 1, 2000.

In the August 1, 2000 interim final rule with comment period, we provided a detailed discussion of the development of the Goldsmith Modifications (65 FR 47029). The Goldsmith Modification evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) in order to establish an operational definition of rural populations lacking easy geographic access to health services. Using 1980 census data, Dr. Harold F. Goldsmith and his associates created a methodology for identification of rural census tracts that were located within a large metropolitan county of at least 1,225 miles but were so isolated from the metropolitan core by distance or physical features so as to be more rural than urban in character. We utilize data based on 1990 census data, reflecting the most recent Goldsmith modification.

We also included Appendix A of that interim final rule with comment period a listing of the identified urban counties with census tracts that may qualify as rural under the most recent Goldsmith Modification (January 1, 2000). The amendments made by section 401 of Public Law 106–113 enable a hospital located in one of the areas listed in Appendix A of the August 1, 2000 interim final rule with comment period to be treated as if it were situated in the rural area of the State in which it is located.

Additionally, section 401(a) of Public Law 106–113 includes hospitals ''* * * located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).'' Since the concept of State ''designation'' referred to in the parenthetical clause was not explicit enough to provide a clear-cut rule for purposes of implementation, we required that a hospital's designation as rural be in the form of either State law or regulation if it is the basis for a hospital's request for urban to rural reclassification. We believe this will help ensure that the provision is implemented consistently among States.

Finally, a hospital also may seek to qualify for reclassification premised on the fact that, had it been located in a rural area, it would have qualified as a rural referral center or as an SCH. The hospital would need to satisfy the criteria set forth in section 1886(d)(5)(C) of the Act (as implemented in regulations at § 412.96) as a rural referral center, or the criteria set forth in section 1886(d)(5)(D) of the Act (as implemented in regulations at § 412.92) as an SCH.

Although the statute authorizes the Secretary to specify further qualifying criteria for a section 401 reclassification, we did not believe that additional criteria were warranted at the time the August 1, 2002 interim final rule was published. However, we invited comment specifically on whether the criteria in the interim final rule are sufficient at this time, and if not, what additional criteria should be incorporated.

A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 *et seq.*), wage index (§ 412.63), and the DSH payment adjustment calculations (§ 412.106) as of the effective date of the reclassification.

Comment: One commenter addressed policies discussed in the August 1, 2000 interim final rule with comment period. Other commenters addressed our policy to not permit hospitals that are redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassifications by the MGCRB.

Response: These policies were addressed in the May 5, 2000 proposed rule (65 FR 26308) and the August 1, 2000 final rule (65 FR 47087) implementing the updates and policy changes to the prospective payment system for FY 2001. We responded to comments on the May 5, 2000 proposed rule in the August 1, 2000 final rule. Because we addressed these concerns in that final rule, we are not readdressing those comments in this final rule.

Comment: An association of physicians commented that the interim final rule with comment period stated that a hospital that is reclassified as rural under this provision must be treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system, including standardized amount, wage index, and the DSH payment adjustment. However, the commenter pointed out, graduate medical education is not listed. The commenter urged that these hospitals also be considered rural for purposes of graduate medical education.

Response: Section 1886(d)(8)(E) of the Act provides that affected hospitals are considered rural for purposes of section 1886(d). Therefore, these reclassifications affect payments to a hospital under the IME adjustment, which are made under section 1886(d)(5)(B) of the Act, but not payments for direct GME, which are made under section 1886(h) of the Act.

2. Conforming Changes under Section 401(b) of Public Law 106–113

Section 401(b) of Public Law 106–113 sets forth conforming statutory changes relating to urban to rural reclassifications under section 401(a) of Public Law 106–113:

• Section 401(b)(1) provided that if a hospital is being treated as being located in a rural area under section 1886(d)(8)(E) of the Act (for purposes of section 1886(d) of the Act), the hospital will also be treated under section 1833(t) of the Act as being located in a rural area. This provision was addressed in the final rule for the hospital inpatient prospective payment system published in the **Federal Register** on August 1, 2000 (65 FR 47087).

• Section 401(b)(2) amended section 1820(c)(2)(B)(i) of the Act by extending the reclassification provisions of section 401(a) to the CAH program. A hospital that otherwise would have fulfilled the requirements for designation as a CAH had it been located in a rural area is now eligible for consideration as a CAH if it is treated as being located in a rural area under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113. (A list of certain existing hospitals that were identified as being located in Goldsmith areas was included in Appendix B of the August 1, 2000 interim final rule with comment period.) A more detailed discussion of the effect on the CAH program of this provision, as well as additional amendments to section 1820(c)(2)(B)(i) of the Act included in Public Law 106–113, is provided in section VI.B. of this preamble.

3. Application Procedures

The statute provides that a hospital seeking reclassification from urban to rural under section 1886(d)(8)(E) of the Act must submit an application ''in a form and manner determined by the Secretary.'' In the August 1, 2000 interim final rule with comment period, we set forth procedures and requirements for the application for rural reclassification, including application submittal requirements, the filing and effective dates for the application, the procedures for withdrawal of applications, and cancellation of rural reclassification; and the qualifications through the Goldsmith Modification Criteria, by State designation and qualifications as a rural referral center or as an SCH. (See 65 FR 47030 through 47031 for a full discussion of these procedures and requirements.) As of early July 2001, 19 hospitals had taken advantage of this provision.

4. Changes in the Regulations

In the August 1, 2000 interim final rule with comment period, we added a new § 412.103 to incorporate the provisions on the urban to rural reclassification options set forth in section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, and the application procedures for requesting reclassification.

A formula for transition payments to hospitals located in an area that has undergone geographic reclassification from urban to rural is set forth in section 1886(d)(8)(A) of the Act and implemented in regulations at §§ 412.90 and 412.102. In the interim final rule with comment period, we revised existing §§ 412.63(b)(1) and 412.90(e) and the title of § 412.102 to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural.

In addition, we revised § 485.610 by redesignating paragraph (b)(4) as paragraph (b)(5) and adding a new paragraph (b)(4) to reflect the conforming provision of section 401(b)(2) of Public Law 106–113.

We did not receive any comments on these changes in the regulations in the interim final rule with comment period and, therefore, are adopting them as final.

G. Medicare Geographic Classification Review Board (MGCRB) (New § 412.235 and Existing §§ 412.256, 412.273, 412.274(b), and 412.276)

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

As discussed in section III.F. of this final rule, section 304 of Public Law 106–554 contained several provisions related to the wage index and reclassification decisions made by the MGCRB. In summary, section 304 first establishes that hospital reclassification decisions by the MGCRB for wage index purposes are effective for 3 years, beginning with reclassifications for FY 2001. Second, it provides that the MGCRB must use the 3 most recent years of average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and subsequent years. Third, it provides that an appropriate statewide entity may apply to have all of the geographic areas in a State treated as a single geographic area for purposes of computing and applying the wage index, for reclassifications beginning in FY 2003. In the May 4, 2001 proposed rule, we presented a discussion of how we proposed to implement these three provisions. (Section III.F. of this preamble discusses the application of these policy changes to the development of the final FY 2002 and later wage indexes based on hospital reclassification under the provisions of section 304 of Public Law 106–554.)

1. Three-Year Reclassifications for Wage Index Purposes

Section 304(a) of Public Law 106–554 amended section 1886(d)(10)(D) of the Act by adding clause (v), which provides that, if a hospital is approved for reclassification by the MGCRB for purposes of the wage index, the reclassification is effective for 3 years. The amendment made by section 304(a) is effective for reclassifications for FY 2001 and subsequent years. In addition, the legislation specifies that the Secretary must establish a mechanism under which a hospital may elect to terminate such reclassification during the 3-year period.

Consistent with new section 1886(d)(10)(D)(v) of the Act, in the May 4 proposed rule, we proposed to revise § 412.274(b) to provide under new paragraph (b)(2) that any hospital that is reclassified for a particular fiscal year for purposes of receiving the wage index value of another area would receive that reclassification for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year in which a hospital files a complete application. This 3-year reclassification would remain in effect unless the hospital terminates the reclassification under revised procedures that we proposed to establish under new proposed § 412.273(b). The provision would apply to hospitals that are reclassified for purposes of the wage index only, as well as those that are reclassified for both the wage index and the standardized amount. However, in the latter case, only the wage index reclassification would be extended for 2 additional

years beyond the 1 year provided for in the existing regulations (3 years total). Hospitals seeking reclassification for purposes of the standardized amount must continue to reapply to the MGCRB on an annual basis.

a. Special Rule for a Hospital that was Reclassified for FY 2001 and FY 2002 to Different Areas

Because the 3-year effect of the amendment made by section 304(a) of Public Law 106–554 is applicable to reclassifications for FY 2001 (which had already taken place prior to the date of enactment of section 304(a) (December 21, 2000)), and because the application process for reclassifications for FY 2002 had already been completed by the date of enactment, we are establishing special procedures for hospitals that are reclassified for purposes of the wage index to one area for FY 2001, and are reclassified for purposes of the wage index or the standardized amount to another area for FY 2002. We are deeming such a hospital to be reclassified to the area for which it applied for FY 2002, unless the hospital elects to receive the wage index reclassification it was granted for FY 2001. Consistent with our procedures for withdrawing an application for reclassification (§ 412.273), we allowed a hospital that wished to receive the reclassification it was granted for FY 2001 to withdraw its FY 2002 application by making a written request to the MGCRB within 45 days of the publication date of the proposed rule (that is, by June 18, 2001). Again, only the wage index reclassification is extended for 2 additional years (3 years total). Hospitals seeking reclassification for purposes of the standardized amount must continue to reapply to the MGCRB on an annual basis.

(We note that, effective May 21, 2001, the new location and mailing address of the MGCRB and the Provider Reimbursement Review Board (PRRB) is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670. Please specify whether the mail is intended for the MGCRB or the PRRB.)

b. Overlapping Reclassifications Are Not Permitted

Under the broad authority delegated to the Secretary by section 1886(d)(10) of the Act, in the May 4 proposed rule, we proposed that a hospital that is reclassified to an area for purposes of the wage index may not extend the 3-year effect of the reclassification under section 304(a) of Public Law 106–554 by subsequently applying for reclassification to the same area for purposes of the wage index for a fiscal year that would be within the 3-year period. For example, if a hospital is reclassified for purposes of the wage index to Area A for FY 2002, is approved to receive Area A's wage index for 3 years (FYs 2002, 2003, and 2004), and reapplies to be reclassified to Area A for FYs 2003, 2004, and 2005 (3 years) for purposes of the wage index, the hospital would not be permitted to receive Area A's wage index for FY 2005 as a result of the reapplication. Instead, we proposed that if the hospital wishes to extend the FY 2002 3-year reclassification for fiscal years beyond FY 2004, it would have to apply for reclassification for FY 2005.

We believe new section 1886(d)(10)(D)(v) of the Act replaces the current annual wage index reclassification cycle with a 3-year reclassification cycle. We believe this policy was intended to provide consistency and predictability in hospital reclassification and wage index data, as well as to alleviate the year-to-year fluctuations in the ability of some hospitals to qualify for reclassification. We do not believe it was intended to be used to extend reclassifications for which hospitals otherwise would not be eligible (by reapplying during the second year of a 3-year reclassification because a hospital fears it may not be eligible for reclassification after its current 3-year reclassification expires).

c. Withdrawals of Applications and Terminations of Approved Reclassifications

(1) General

Under § 412.273(a), a hospital, or group of hospitals, may withdraw its application for reclassification at any time before the MGCRB issues its decision or, if after the MGCRB issues its decision, within 45 days of publication of our annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application was filed. In the May 4 proposed rule, we proposed that the withdrawal procedures and the applicable timeframes in the existing regulations would apply to hospitals that would receive 3-year reclassification for wage index purposes. For example, if a hospital applied for reclassification to Area A for purposes of the wage index for FY 2002, but wished to withdraw its application, it must have done so prior to the MGCRB issuing a decision on its application or, if the MGCRB issued such a decision, within 45 days of the publication date of the proposed rule (that is, by June 18, 2001). Such a withdrawal, if effective, means that the hospital would not be reclassified to Area A for purposes of the wage index for FY 2002 (and would not receive continued reclassification for FYs 2003 and 2004), unless the hospital subsequently cancels its withdrawal (as discussed below). In other words, a withdrawal, if accepted, prevents a reclassification from ever becoming effective.

On the other hand, a reclassification decision that is terminated upon the request of the hospital has partial effect. Section 1886(d)(10)(D)(v) of the Act, as added by section 304(a) of Public Law 106–554, provides that a reclassification for purposes of the wage index is effective for 3 years ''except that the Secretary shall establish procedures under which a . . . hospital may elect to terminate such reclassification before the end of such period.'' Consistent with section 1886(d)(10)(D)(v) of the Act, we proposed to allow a hospital to terminate its approved 3-year reclassification for 1 or 2 years of the 3-year effective period (§ 412.273(b)). This is a separate action from a reclassification withdrawal, which occurs following the initial decision by the MGCRB. A termination would occur during subsequent years. For example, a hospital that has been reclassified for purposes of the wage index for FY 2001 is also reclassified for FYs 2002 and 2003 (3 years). Such a hospital could terminate its approved reclassification so that the reclassification is effective only for FY 2001, or only for FYs 2001 and 2002. Consistent with the prospective nature of reclassifications, we proposed to not permit a hospital to terminate its approved 3-year reclassification for part of a fiscal year. A termination would be effective for the next fiscal year. In order to terminate an approved 3-year reclassification, we would require the hospital to notify the MGCRB in writing within 45 days of the publication date of the annual proposed rule for changes to the inpatient hospital prospective payment system. A termination, unless subsequently cancelled (as discussed below), is effective for the balance of the 3-year period.

We established a special procedural rule for handling FY 2001 reclassifications. As noted above, the amendments made by section 304(a) of Public Law 106–554 are effective for reclassifications for FYs 2001 and beyond, and reclassification decisions for FY 2001 had already been implemented prior to the date of enactment of section 304(a). We deemed those hospitals that were reclassified for

FY 2001 to be reclassified for FYs 2002 and 2003. Therefore, if a deemed hospital that was reclassified for purposes of the wage index for FY 2001 wished to terminate its reclassification for FY 2002 and FY 2003, the hospital had to notify the MGCRB in writing by June 18, 2001 (that is, within 45 days after the publication of the proposed rule).

(2) Cancellation of a Withdrawal of Application or a Termination of an Approved Reclassification

In the May 4 proposed rule, we proposed that if a hospital elects to withdraw its 3-year reclassification application after the MGCRB has issued its decision, it may cancel its withdrawal in a subsequent fiscal year and request the MGCRB to reinstate its reclassification for the remaining fiscal years of the 3-year reclassification period. (This proposal was consistent with our proposal that 3-year reclassification periods may not overlap, as discussed in section IV.G.1.b. of this preamble.) Alternatively, a hospital may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified), and if successful, the reclassification effect would be for 3 years.

Similarly, and for the same reasons, we proposed that if a hospital elects to terminate its accepted 3-year reclassification prior to the second or third year of that reclassification, it may cancel that termination and have its original reclassification reinstated for the duration of the original 3-year period. Alternatively, a hospital could apply for reclassification to a different area after terminating a prior 3-year reclassification and receive a new 3-year period of reclassification.

Example 1: Hospital A files an application and the MGCRB issues a decision to reclassify it to Area B for purposes of wage index for FY 2002 through FY 2004 (3 years). Within 45 days after the publication of the proposed rule, Hospital A withdraws its application. Within the time for applying for a FY 2003 reclassification, Hospital A cancels its withdrawal for classification to Area B. Its reclassification to Area B is reinstated, but only for FYs 2003 and 2004.

Example 2: Hospital B files an application for reclassification for wage index purposes for FY 2002 through FY 2004 and the MGCRB issues a decision for reclassification to Area C. Within 45 days after publication of the proposed rule, Hospital B withdraws its application. Hospital B does not cancel its withdrawal of the application. Hospital B timely applies and is reclassified to Area D for 3 years, beginning with FY 2003. In this case, the reclassification to Area D would be for FYs 2003 through 2005.

Example 3: Hospital C is reclassified to Area A for purposes of the wage index for FY 2002, and terminates its 3-year reclassification effective for FYs 2003 and 2004. Within the timeframe for applying for FY 2004 reclassification, Hospital C cancels its termination. Its reclassification to Area A would be reinstated for FY 2004 only.

Example 4: Hospital D has the same circumstances as Hospital C in Example 3, except that instead of canceling its termination, Hospital D applies and is reclassified to Area B for FY 2004. In this case, the reclassification would be for FYs 2004 through 2006.

d. Special Rules for Group Reclassifications

Section 412.232 discusses situations where all hospitals in a rural county are seeking urban redesignation, and § 412.234 discusses criteria where all hospitals in an urban county are seeking redesignation to another urban county. In these cases, hospitals submit an application as a group, and all hospitals in the county must be a party to the application. The reclassification is effective both for purposes of the wage index and the standardized amount of the area to which the hospitals are reclassified.

Section 304(a) of Public Law 106–554 does not specifically address the group reclassification situations under §§ 412.232 and 412.234. However, we believe that, in the case of hospitals reclassified under these group reclassification procedures, it would be appropriate to extend the 3-year reclassification provision to these situations for the wage index only. In order to be reclassified for the standardized amount during the second and third years of a 3-year reclassification for the wage index, the hospitals located in these counties would have to reapply on an annual basis to the MGCRB either as a group or as individual hospitals and meet the criteria outlined in § 412.232, § 412.234, or § 412.230, as appropriate.

Hospitals that are part of a group reclassification would be able to terminate their 3-year wage index reclassifications in the same manner as described above. If one hospital within the group elects to terminate its 3-year wage index reclassification, the reclassification of other hospitals in the group would be unaffected. The same rules for withdrawing from a group reclassification that are in effect now would continue. That is, all of the hospitals that are party to a group reclassification application must consent for a withdrawal to be approved.

Under section 152(b) of Public Law 106–113, hospitals in certain counties were deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. Section 152(b) also requires that these reclassifications be treated for FY 2001 as though they are reclassification decisions by the MGCRB. For purposes of applying the 3-year extension of wage index reclassifications, we proposed to extend section 1886(d)(10)(D)(v) to hospitals reclassified under section 152(b) of Public Law 106–113. These hospitals also would have to apply for the standardized amount on an annual basis to the MGCRB.

e. Administrator Authority to Cancel Inappropriate Reclassification Decisions

In the proposed rule we indicated that, under the provisions of § 412.278(g), the Administrator has the authority to review an inappropriate reclassification decision made by the MGCRB, as discovered by either the hospital or CMS, including 3-year reclassifications in the second and third years. The statement that this authority extended to the second and third years of 3-year reclassification was in error. Under the statute and our regulations, reclassification decisions are unreviewable once they become final. This principle applies to 3-year reclassification decisions. Once such a decision becomes final, it is unreviewable thereafter.

Comment: Several commenters expressed concern that we proposed that a hospital that is reclassified to an area for purposes of the wage index may not extend the 3-year effect of the reclassification under section 304(a) of Public Law 106–554, by subsequently applying for reclassification to the same area for purposes of the wage index for a fiscal year that would be within the 3-year period. These commenters argued that there is nothing in the statutory language that prohibits hospitals that are already approved for 3-year reclassifications from reapplying within that 3-year period to extend their reclassifications into future years. These commenters also pointed out that extending their wage index reclassifications in this way allows them to make budgetary commitments further into the future and fosters a more stable operating environment for their hospitals.

Response: Under section 1886(d)(10) of the Act, the Secretary has broad authority to establish policies and

criteria with respect to the evaluation and approval of applications for reclassification. As indicated in the proposed rule, we believe that new section 1886(d)(10)(D)(v) of the Act, as added by section 304(a) of Public Law 106–554, replaces the annual reclassification cycle with a 3-year reclassification cycle. We believe that, if a hospital is already reclassified to a given geographic area for a 3-year period, it is appropriate to avoid expending resources to evaluate an application for reclassification to that same area for the second and third years of the 3-year period. Thus, if a hospital is already reclassified for a given fiscal year, and submits an application for reclassification to the same area for the same year, that application will not be approved. We are adding language to § 412.230(a)(5)(v) in this final rule to specify that an application for reclassification will not be approved under these circumstances.

Comment: One commenter supported our proposal to reclassify a hospital based on its FY 2002 approval unless the hospital notified the MGCRB otherwise by June 18, 2001. This commenter questioned whether or not hospitals would have this same option in future years. In other words, if a hospital successfully sought reclassification to a different area for FY 2003 and then withdrew that reclassification, would that hospital have the option to fall back on the FY 2002 reclassification, or would it then not be reclassified.

Response: We appreciate the commenter's support of our proposal on this issue. This was specifically put in place because the new 3-year reclassification policy was not enacted until well after the reclassification process for FY 2002 was underway. Therefore, some hospitals may have sought reclassification to a different area or for a different purpose than they did for FY 2001, and the option to carry forward a FY 2001 wage index reclassification for 3 years may have changed their decisions.

This policy applies in future years as well. For example, a hospital that successfully seeks reclassification for the wage index for FY 2004 to Area A, then successfully seeks reclassification for FY 2005 for the wage index to Area B, has the option to withdraw its FY 2005 decision, thereby reinstating its FY 2004 decision. However, if the hospital successfully withdraws its FY 2005 decision, the hospital cannot return to its FY 2005 decision without reapplying at a later date.

Comment: Several commenters expressed uncertainty about the timing of the extension of the wage index reclassification for 3 years. Some hospitals had successfully applied for FY 2001 as well as FY 2002 to the same area for the wage index, and it was not clear to these hospitals whether their wage index reclassifications were effective through FY 2003 or through FY 2004.

Response: As noted above, section 304(a) provides for 3-year wage index reclassifications effective with FY 2001 reclassifications. In the case of hospitals reclassified to the same area for both FY 2001 and FY 2002, because hospitals had already submitted their FY 2002 applications prior to enactment of Public Law 106–554, and the MGCRB had already issued its decision on these applications prior to publication of the May 4 proposed rule, we will consider FY 2002 to be the first year of the 3-year reclassification for these hospitals. Therefore, the reclassification period will extend through FY 2004. If a hospital was approved for FY 2001 for a wage index reclassification, but was unsuccessful in seeking a wage index reclassification for FY 2002, then its wage index reclassification would be effective for FY 2001, FY 2002, and FY 2003, and the hospital would have to reapply to seek reclassification for FY 2004.

Comment: One commenter supported our proposal that a hospital could cancel its withdrawal of an approved reclassification for the wage index in a future year in order to reinstate its original MGCRB approval.

Response: We appreciate the commenter's support of our proposal that hospitals reclassified for the wage index that then withdraw that approval have the ability to cancel the withdrawal, in effect reinstating the hospital's original reclassification approval for the wage index. We provided this option so that a hospital that later discovers that the withdrawal of its approved wage index reclassification was disadvantageous would have the ability to reinstate its MGCRB approval for the wage index for the remaining years in the 3-year term. However, a hospital is eligible to revert to its most recent MGCRB approval only.

In addition, the same process applies to cancellations of a withdrawal or termination as applies to requests for withdrawals and terminations. A hospital must request a cancellation of its withdrawal or termination within the 45-day period after the proposed rule is published, and that cancellation will become effective for the following Federal fiscal year.

Comment: Several commenters supported our proposal to extend the 3-year reclassification provision for the wage index to those hospitals that were reclassified for FY 2001 under section 152(b) of Public Law 106–113. While these hospitals did not successfully apply for reclassification through the MGCRB, they were effectively ''reclassified'' by this legislation, and the commenters believed that it would be correct to extend the 3-year wage index reclassification to this group of hospitals.

Response: We appreciate the commenters' support of our proposal. Section 152(b) of Public Law 106–113 required that the assignment of these hospitals to alternative geographic areas should be treated as if they were decisions of the MGCRB. As a result, these hospitals will be reclassified for the wage index to their designated areas for FY 2002 and FY 2003. They will be required to apply for reclassification to the MGCRB for FY 2004 if they wish to retain this reclassification for subsequent years.

2. Three-Year Average Hourly Wages

Section 304(a) of Public Law 106–554 amended section 1886(d)(10)(D) of the Act by adding clause (vi) which provides that the MGCRB must use the average of the 3 most recent years of hourly wage data for the hospital when evaluating a hospital's request for reclassification. Specifically, the MGCRB must base its evaluation on an average of the average hourly wage for the most recent years for the hospital seeking reclassification and the area to which the hospital seeks to reclassify. This provision is effective for reclassifications for FY 2003 and subsequent years. (Section III.F. of this preamble discusses the development and application of the hospital's 3-year average hourly wage data (Table 2 in the Addendum to this final rule) that the MGCRB will use to evaluate hospitals' applications for reclassifications for FY 2003; and the MSA and statewide rural 3-year average hourly wage data (Tables 3A and 3B in the Addendum to this final rule) for hospital reclassification applications for FY 2003.)

In the May 4, 2001 proposed rule, we proposed to revise §§ 412.230(e)(2) and 412.232(d)(2) to incorporate the provisions of section 1886(d)(10)(D)(vi) of the Act as added by section 304(a) of Public Law 106–554. Specifically, we provided that, for redesignations effective beginning FY 2003, for hospital-specific data, the hospital must provide a 3-year average of its average hourly wages using data from our hospital wage survey used to construct

the wage index in effect for prospective payment purposes. For data for other hospitals, we proposed to require hospitals to provide a 3-year average of the average hourly wage in the area in which the hospital is located and a 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data would be taken from the CMS hospital wage survey used to construct the wage index for prospective payment purposes, as published in Tables 2, 3A, and 3B of this final rule (unless those data are subsequently changed by CMS). The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described in section III. of this final rule) across all 3 years, by the sum of the hours.

Comment: Several commenters responded positively to our proposal to use a 3-year average of the most recent 3 years of average hourly wages based on data from our hospital wage survey used to construct the wage index when evaluating a hospital's request for reclassification. Under the proposal, if data does not exist for all 3 years, the available data within the 3-year period will be used to construct the average.

While it was clear to these commenters that these data will be used to construct the average hourly wage for a hospital applying for reclassification, they noted it was not clear to them whether the 3-year average would also be used for the area in which that hospital is physically located as well as the area to which that hospital seeks reclassification.

Response: We appreciate the commenters' support of our proposal to calculate the 3-year average hourly wage based on the data available during the applicable 3-year period, even if a hospital does not have data in all 3 years.

As noted above, the MGCRB will evaluate applications using the 3-year average hourly wages for hospitals and geographic areas as published in Tables 2, 3A, and 3B of this final rule (unless those data are subsequently changed by CMS).

Comment: One commenter requested that in cases of a change in ownership, a hospital be permitted the option of excluding prior years' wage data submitted by a previous owner for the purpose of calculating the average of the average hourly wages in order to qualify for reclassification. As a result, the average of the average hourly wages would be based on current and prior year data submitted by the new owner only.

Response: We believe we should treat these cases in a manner consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. That is, where a hospital has simply changed ownership and the new owners have acquired the assets and liabilities of the previous owners, all of the applicable wage data associated with that hospital are included in the calculation of its 3-year average hourly wage. On the other hand, in the case of a new hospital, where there is no legal obligation to the operations of a predecessor hospital, the wage data associated with the previous hospital's provider number would not be used in calculating the new hospital's 3-year average hourly wage.

3. Statewide Wage Index

As stated earlier, section 304(b) of Public Law 106–554 provides for a process under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index for reclassifications beginning in FY 2003.

Section 304 does not indicate the duration of the application of these statewide wage indexes. However, it should be noted that the statutory language does refer to these applications as reclassifications. In the May 4, 2001 proposed rule, we proposed that these statewide wage index applications be processed similar to MGCRB applications, with the same effective dates of the decisions and the withdrawal and termination process. Therefore, similar to wage index reclassification decisions under section 1886(d)(10)(D)(v) of the Act as added by section 304(a) of Public Law 106–554, the statewide wage index reclassification would be effective for a total of 3 years. The same deadlines and timetable applicable to MGCRB reclassification applications would apply for statewide wage index applications.

We proposed to establish a new § 412.235 to include the requirements for statewide wage indexes. We proposed to apply the following criteria to determine whether hospitals would be approved for a statewide geographic wage index reclassification (§ 412.235(a)):

- There must be unanimous support for a statewide wage index among hospitals in the State in which the statewide wage index would be applied. We would require a signed affidavit on behalf of all the hospitals in the State of this support as part of the application for reclassification.
- All hospitals in the State must apply through a signed single application for the statewide wage index in order for the application to be considered by the MGCRB. We believe this is necessary to ensure that every hospital in the State is included in the application, since the payment of every hospital would be affected by the statewide wage index.
- There must be unanimous support for the termination or withdrawal of a statewide wage index among hospitals in the State in which the statewide wage index would be applied. We would require a signed affidavit for this agreement.
- All hospitals in the State waive their rights to any wage index that they would otherwise receive absent the statewide wage index, including a wage index that any of the hospitals might have received through individual or group geographic reclassification under § 412.273(a).

An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its wage index otherwise (§ 412.235(b)). Specifically, hospitals must be aware that there may be a reduction in the wage index as a result of participation on a statewide basis.

In addition, we proposed to consider statewide wage index applications under the same process we use for hospital reclassification applications, including the effective dates of the MGCRB decision and the withdrawal and termination process (§ 412.235(c)). We proposed that applications for the statewide wage index would be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals file a complete application unless all of the participating hospitals withdraw their application or terminate their approved statewide wage index reclassification earlier, as discussed below. Once approved by the MGCRB, an application for a statewide wage index can only be withdrawn or terminated as a result of a signed affidavit on behalf of all the hospitals in the State indicating their request that the statewide reclassification be withdrawn or terminated. A request for withdrawal or termination must be submitted within 45 days of the publication of the annual proposed rule for the inpatient hospital prospective payment system announcing the reclassification. New hospitals that open prior to the September 1 deadline for submitting an application for a statewide wage index, but after a group

application has been submitted, would be required to agree to the statewide wage index in order for the group application to remain viable. New hospitals that open after the deadline for submitting an application would receive the statewide wage index. The agreement of new hospitals would also be required in order to withdraw or terminate a statewide wage index reclassification. The rules discussed under section IV.G.1.c. of this preamble for withdrawals of applications and terminations of approved 3-year wage index reclassification decisions would apply to decisions regarding statewide wage index reclassifications.

Comment: Several commenters believed that Washington, DC should be recognized as a State for purposes of this statewide wage index reclassification policy. However, they were concerned that, while such a recognition may benefit hospitals located in Washington, DC, it may not benefit hospitals that are currently located outside of Washington, DC but within the Washington, D.C.–MD–VA–WV MSA. As a result, while these commenters believed that Washington, DC should be recognized as a State for this purpose, they also requested guidance about how the remainder of the hospitals in the current MSA would be treated.

One commenter did not believe that Washington, DC should be considered a State for this purpose. However, this commenter also stated that, should we decide that Washington, DC could be considered a State for this purpose, we should configure the criteria such that none of the hospitals that are currently located in the Washington, D.C.–MD–VA–WV MSA would be harmed.

Response: Section 304(b) of Public Law 106–554 directs the Secretary to establish a process ''under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of [the Social Security] Act. * * *'' Most States encompass multiple labor market areas (urban MSAs and rural areas) with differing wage indexes, and we believe that the intent of section 304(b) is to offer hospitals within a State the opportunity to eliminate the disparate wage indexes resulting from separate urban and rural labor market areas within the State. However, hospitals in Washington, DC are not subject to disparate wage indexes. Washington, DC is part of a larger labor market area where all the hospitals receive the wage index for that labor market area (subject to MGCRB reclassifications). Put another way, Washington, DC is *already* ''treated as a single geographic area'' for purposes of the hospital wage index.

If we treated Washington, DC as a separate distinct labor market area and applied the usual wage index methodology, Washington, DC hospitals might reap a significant windfall and the hospitals remaining in the MSA might be disadvantaged. Given the intended purpose of section 304(b), we believe that such results would be inappropriate. We believe that Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC.

As indicated above, section 304(b) permits a State to be treated as a single geographic area ''for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of [the] Act.'' Section 304(b) does not specify how to compute and apply the wage index for statewide geographic areas. Under section 1886(d)(3)(E) of the Act, the Secretary has broad authority to develop and apply the methodology for determining the wage index for labor market areas, and section 304(b) did not limit the agency's authority. Thus, even if Washington, DC is a State for purposes of section 304(b), the Secretary has broad authority under section 1886(d)(3)(E) to determine the wage index for all affected hospitals. Given the purpose of section 304, and to avoid conferring an inappropriate and unintended windfall (or disadvantage) to hospitals, we are providing (pursuant to our broad authority under section 1886(d)(3)(E) of the Act) that, even if Washington, DC is a State for purposes of section 304(b) of Public Law 106–554, the wage index applicable to the Washington, DC ''statewide'' geographic area would be the same wage index that would apply to the Washington, DC–MD–VA–WV MSA as a whole (which would be calculated by including Washington, DC hospitals, in accordance with all applicable rules).

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

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 1886(h)(2) of the Act, as amended by section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99–272), and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as amended by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of FTE residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care and obstetrics and gynecology residents and nonprimary care residents have two separate PRAs beginning in FY 1994: one for primary care and obstetrics and gynecology and one for nonprimary care.

Section 1886(h)(2) of the Act was further amended by section 311 of Public Law 106–113 to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2) of the Act establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised. PRAs that are below the floor, that is, 70 percent of the locality-adjusted, updated, weighted average PRA, would be revised to equal 70 percent of the locality-adjusted, updated, weighted average PRA. PRAs that exceed the ceiling, that is, 140 percent of the locality-adjusted, updated, weighted average PRA, would, depending on the fiscal year, either be frozen and not increased for inflation, or increased by a reduced inflation factor.

We implemented section 311 of Public Law 106–113 in the hospital inpatient prospective payment system final rule published on August 1, 2000 (65 FR 47090). In that final rule, we set forth the methodology for calculating the weighted average PRA and outlined the steps for determining whether a hospital's PRA would be revised.

2. Amendments Made by Section 511 of Public Law 106–554 (§ 413.86(e)(4)(ii)(C) and (e)(5)(iv))

Section 511 of Public Law 106–554 amended section 1886(h)(2)(D)(iii) of the Act by increasing the floor to 85 percent of the locality-adjusted national average PRA. In general, section 511 provides that, effective for cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, PRAs that are below 85 percent of the respective locality-adjusted national average PRA would be increased to equal 85 percent of that locality-adjusted national average PRA. Accordingly, we proposed to implement section 511 by revising § 413.86(e)(4)(ii)(C)(*1*) to incorporate this change and by outlining the methodology for determining whether a hospital's PRA(s) will be adjusted in FY 2002 relative to the increased floor of the locality-adjusted national average PRA.

In the August 1, 2000 final rule (65 FR 47091 and 47092), as implemented at § 413.86(e)(4), we determined, in accordance with section 311 of Public Law 106–113, that the weighted average PRA for cost reporting periods ending during FY 1997 is $68,464. We described the procedures for updating the weighted average PRA of $68,464 for inflation to FY 2001 and for adjusting this average for the locality of each individual hospital. We then outlined the steps for comparing each hospital's PRA(s) to the locality-adjusted national average PRA to determine if, for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the PRAs should be revised to equal the 70-percent floor.

In accordance with section 511 of Public Law 106–554, in the May 4 proposed rule, we proposed that, for cost reporting periods beginning during FY 2002, the FY 2002 PRAs of hospitals that are below 85 percent of the respective locality-adjusted national average PRA for FY 2002 be increased to equal 85 percent of that locality-adjusted national average PRA. Specifically, to determine which PRAs (primary care and nonprimary care separately) for each hospital are below the 85-percent floor, each hospital's locality-adjusted national average PRA for FY 2002 is multiplied by 85 percent. This resulting number is then compared to each hospital's PRA that is updated for inflation to FY 2002. If the hospital's PRA would be less than 85 percent of the locality-adjusted national average PRA, the individual PRA is *replaced* with 85 percent of the locality-adjusted national average PRA for that cost reporting period, and in future years the new PRA would be updated for inflation by the Consumer Price Index for All Urban Consumers (CPI–U) as compiled by the Bureau of Labor Statistics.

There may be some hospitals with both primary care and nonprimary care PRAs that are below the floor, and both PRAs are, therefore, replaced with 85 percent of the locality-adjusted national average PRA. In these situations, the hospitals would receive a single PRA; a distinction between PRAs would no longer be made based on the different inflation adjustments (under § 413.86(e)(3)(ii)). On the other hand, hospitals may have primary care PRAs that are above the floor, and nonprimary care PRAs that are below the floor. In these situations, only the nonprimary care PRAs would be revised to equal 85 percent of the locality adjusted national average PRA, and the prior year primary care PRAs would be updated for inflation by the CPI–U. An example of application of this provision appeared in the preamble of the May 4, 2001 proposed rule (66 FR 33697).

We note that section 511 of Public Law 106–554 only affects hospitals with PRAs below the 85-percent floor, and does not affect hospitals with PRAs that are either between the floor and ceiling or exceed the ceiling. Thus, with the exception of the change in the floor as provided by section 511, the policy regarding the use of a national average PRA for making direct GME payments remains as implemented in the regulations at § 413.86(e)(4).

We proposed to amend § 413.86(e)(4)(ii)(C)(*1*) to add the rules implementing section 1886(h)(2)(D)(iii) of the Act as amended by section 511 of Public Law 106–554.

We also proposed to amend § 413.86(e)(5) regarding the determination of base year PRAs for new teaching hospitals for cost reporting periods beginning during FYs 2001 through 2005. In the August 1, 2000 final rule, we made a conforming change to § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base year PRA and establish a PRA in a cost reporting period after the 1984 base year. Existing § 413.86(e)(5)(iv) specifies that the new base year PRAs of such hospitals are subject to the regulations regarding the floor and the ceiling of the locality-adjusted national average PRA. Although the determination of new base year PRAs is subject to the national average methodology, it is not necessary to include this provision in the regulations. Therefore, we proposed to remove § 413.86(e)(5)(iv).

In the proposed rule, we clarified that, for purposes of calculating a base year PRA for a new teaching hospital, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean value of the PRAs in the hospital's census region (as defined in § 412.62(f)(1)(i)), the PRAs used in the weighted average calculation must not be less than the floors for cost reporting periods beginning during FY 2001 or FY 2002, or if they exceed the ceiling, they must either be frozen for FYs 2001 and 2002 or updated with the CPI–U minus 2 percent for FYs 2003 through 2005. In addition, existing § 413.86(e)(5) provides that the PRA for a new teaching hospital is based on the *lower of* the hospital's actual costs incurred in connection with the GME program or the weighted mean value of PRAs. If a hospital's actual costs of the GME program during its cost reporting period beginning during FY 2001 or FY 2002 are *less* than the floors, the hospital's PRA would *not* be based on the actual costs. Instead, it would be equal to 70 percent in FY 2001, or 85 percent during FY 2002, of the locality-adjusted national average PRA. The floor applies to hospitals with existing PRAs in FYs 2001 and 2002, or to hospitals that are establishing new base year PRAs in FYs 2001 and 2002. We proposed to clarify that if a hospital establishes a new base year PRA in a cost reporting period beginning *after* FY 2002, its PRA would *not* be increased to equal the floor if it is less than the floor. Similarly, the ceiling applies to hospitals with existing PRAS in FYs 2001 through 2005, or to hospitals that are establishing new base year PRAs in FYs 2001 through 2005.

Comment: One commenter believed that the provision to increase the PRA floor to 85 percent of the locality-adjusted national average will address many concerns about the fairness of GME payments. One commenter asked if the provisions of the proposed rule to increase PRAs that are less than 85 percent of the locality-adjusted national average PRA to equal 85 percent of the locality-adjusted national average PRA would provide relief to hospitals who do not have base year PRAs established in the 1984 base year and could not increase their PRAs because the appeal period has elapsed.

Response: Section 511 of the Public Law 106–554 amended section 1886(h)(2)(D)(iii) of the Act by increasing the floor to 85 percent of the locality adjusted national average PRA. Effective for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, any PRAs that are below 85 percent of the respective locality-adjusted national average PRA would be increased to equal 85 percent of that locality-adjusted national average PRA. Accordingly, hospitals with PRAs (primary care and/or nonprimary care) that are less than 85 percent of the respective locality-adjusted national average PRA for the hospital's cost reporting period beginning on or after October 1, 2001 and before October 1, 2002, will have those PRAs increased to equal 85 percent of that locality-adjusted national average PRA. This provision sets the floor on per resident amounts for cost reporting periods beginning during FY 2002, regardless of the base year used to establish the hospital's PRA.

Comment: One commenter requested that we clarify the references in the preamble stating that the national average PRA methodology is applicable for ''cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005.'' The commenter believed that the PRA changes authorized in the law were meant to be permanent, and therefore, did not understand the basis for the September 30, 2005 endpoint.

Response: The changes made to a hospital's PRA as a result of section 311 of Public Law 106–113 and section 511 of Public Law 106–554 are permanent. However, this *new methodology* for determining whether or not a hospital's PRA is *revised,* as described in the statute, is only effective for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. For cost reporting periods beginning on or after October 1, 2005, a hospital's PRA, *whether or not it was revised by the new methodology,* is updated with the full CPI–U, using the procedures in place prior to October 1, 2000. If a hospital's PRAs are below the floors, they will be revised accordingly in FYs 2001 or 2002, or both. After FY 2002, that hospital's revised PRA will be updated for inflation as usual, that is, using the procedures in place for all PRAs prior to October 1, 2000. If a hospital's PRAs exceed the ceiling, the PRAs would be frozen in FYs 2001 and 2002, and updated with a reduced inflation factor in FYs 2003, 2004, and 2005. Thus, after September 30, 2005, although any changes made to a hospital's PRAs as a result of the new methodology would remain in place, the procedure for updating PRAs reverts back to the procedure in place prior to October 1, 2000, that is, updating for inflation with the full CPI–U.

Comment: One commenter requested that we publish in the final rule the CPI–U factors that must be used to update the 1997 national average PRA to the midpoint of a hospital's cost reporting period beginning in FY 2001.

Response: As the commenter requested, we are including below the CPI–U factors. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the following update factors should be used when implementing section 311 of Public Law 106–113. Specific instructions for applying these factors can be found in the hospital inpatient prospective payment system final rule published on August 1, 2000 (65 FR 47091). (Refer to the bottom of the middle column and the right column on page 47091 for ''Step 1: Update the weighted average PRA for inflation''.)

GME UPDATE FACTORS FOR MIDPOINT OF PERIODS ENDING IN FY 1997 TO COST REPORTING PERIODS BEGINNING IN FY 2001 USING THE CPI (U)—ALL ITEMS

Update weighted average PRA from:	To midpoint of cost reporting period beginning:	Use update factor of: *
October 1, 1996	October 1, 2000	1.11200
October 1, 1996	November 1, 2000	1.11389
October 1, 1996	December 1, 2000	1.11579
October 1, 1996	January 1, 2001	1.11800
October 1, 1996	February 1, 2001	1.12053
October 1, 1996	March 1, 2001	1.12307
October 1, 1996	April 1, 2001	1.12465
October 1, 1996	May 1, 2001	1.12528
October 1, 1996	June 1, 2001	1.12591
October 1, 1996	July 1, 2001	1.12780
October 1, 1996	August 1, 2001	1.13097
October 1, 1996	September 1, 2001	1.13414

* Source: Forecast by Standard and Poor's DRI; Historical Data through August 2000.

3. Determining the 3-Year Rolling Average for Direct GME Payments (§ 413.86(g)(4) and (g)(5))

Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of Public Law 106–33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for direct GME payment purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the Act requires that hospitals' direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods (rolling average). This provision phases in the associated reduction in payment over a 3-year period for hospitals that are reducing their number of residents.

In the August 29, 1997 final rule with comment period (62 FR 46004), we revised § 413.86(g)(5) accordingly, and outlined the methodology for determining a hospital's direct GME payment. Based on what we explained in the 1997 final rule, for cost reporting periods beginning on or after October 1, 1997, we would determine a hospital's direct GME payment as follows:

Step 1. Determine the average of the weighted FTE counts for the payment year cost reporting period and the prior two immediately preceding cost reporting periods (with exception of the hospital's first cost reporting period beginning on or after October 1, 1997, which will be based on the average of the weighted average for that cost

reporting period and the immediately preceding cost reporting period).

Step 2. Determine the hospital's direct GME amount without regard to the FTE cap (before determining Medicare's share). That is, take the sum of (a) the product of the primary care PRA and the primary care weighted FTE count in the current payment year, and (b) the product of the nonprimary care PRA and the nonprimary care weighted FTE count in the current payment year.

Step 3. Divide the hospital's direct GME amount by the total number of FTE residents (including the effect of weighting factors) for the cost reporting period to determine the weighted average PRA (this amount reflects the FTE weighted average of the primary and nonprimary care PRAs) for the cost reporting period.

Step 4. Multiply the weighted average PRA for the cost reporting period by the 3-year average weighted count to determine the hospital's allowable direct GME costs. This product is then multiplied by the hospital's Medicare patient load for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Steps 2 and 3 above describe the methodology for combining a hospital's primary care PRA and nonprimary care PRA to determine the hospital's single weighted average PRA for the payment year cost reporting period. (This step accounts for hospitals that were training residents in both primary care and nonprimary care residency programs in FYs 1994 and 1995, when, as described in § 413.86(e)(3)(ii), each hospital's PRA for the previous cost reporting period was not adjusted for any resident FTEs who were not either a primary care resident or an obstetrics and a gynecology resident. As a result, such hospitals have two PRAs for direct GME payment; one for primary care and obstetrics and gynecology residents, and one for all other, or nonprimary care, residents. Hospitals that train either only primary care (including obstetrics and gynecology) residents or only nonprimary care residents follow the methodology described above, with the exception of combining two PRAs. Step 4 then dictates that the resulting average PRA is multiplied by the 3-year rolling average, which, in turn, is multiplied by the hospital's Medicare patient load in the current year to determine Medicare's direct GME payment to the hospital for that cost reporting period.

In implementing this provision in the August 29, 1997 final rule with comment period, we believed that the methodology described above was appropriate because it was consistent with the methodology described under section 1886(h)(3)(B) of the Act. This section specifies that, in order to arrive at the average PRA, or ''aggregate approved amount,'' the Secretary must multiply a hospital's PRA by the ''weighted average number of [FTE] residents * * * in the hospital's approved medical residency training programs *in that period*'' (emphasis added).

We also believed the methodology outlined above and in the August 29, 1997 rule was appropriate because it was consistent with the intent of the statute that, after October 1, 1997, direct GME payments should be based on a rolling average. Specifically, section 4623 of Public Law 106–33 provides that, ''For cost reporting periods beginning on or after October 1, 1997 * * * *the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average* of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods' (emphasis added). Thus, while the statute does not include a specific methodology for computing the direct GME payments, it clearly indicates that the payment should be based on a 3-year average of the weighted number of residents, *not* the weighted number of residents in the current payment year cost reporting period.

As stated above, Congress provided that the direct GME payments should be made based on a 3-year average of the weighted number of residents in order to phase in the associated reduction in payment over a 3-year period for hospitals that are reducing the number of residents they are training. However, in steps 2 and 3 above, when combining a hospital's primary care PRA and nonprimary care PRA, we weight the respective PRAs by *current year* residents. This introduces the number of residents that a hospital is training in the *current cost reporting period* into the payment formula. A payment formula that incorporates the number of current year residents ''dilutes'' the effect of the rolling average as related to direct GME payments. After further consideration, we believe that, consistent with the statute, the formula should be based on rolling average counts of residents. We proposed an alternative methodology which would replace the current methodology in which the direct GME payment would be the sum of (a) the product of the primary care PRA and the primary care and obstetrics and gynecology rolling average, and (b) the product of the nonprimary care PRA and the nonprimary care rolling average. (This sum would then be multiplied by the Medicare patient load.) The new methodology would only be used for determining direct GME payments because there is no distinction between primary care and nonprimary care residents for IME payment purposes.

The new methodology is effective for cost reporting periods beginning on or after October 1, 2001. The methodology for determining a hospital's direct GME payment is as follows:

Step 1. Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The proportional reduction is calculated *for primary care and obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)

plus

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).

Add the two products to determine the hospital's reduced cap.

Step 2. Determine the 3-year average of the weighted FTE count for primary care and obstetrics and gynecology residents in the payment year cost reporting period and the two immediately preceding cost reporting periods. Determine the 3-year average of the weighted FTE count for nonprimary care residents in the payment year cost reporting period and the two immediately preceding cost reporting periods.

Step 3. Determine the product of the primary care PRA and the primary care and obstetrics and gynecology 3-year average from step 2. Determine the product of the nonprimary care PRA and the nonprimary care 3-year average from step 2.

Step 4. Sum the products of step 3.

Step 5. Multiply the sum from step 4 by the hospital's Medicare patient load

for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Existing § 413.86(g)(5) specifies that residents in new programs are excluded from the rolling average calculation for a period of years equal to the minimum accredited length for the type of program, and are added to the payment formula after applying the averaging rules. Accordingly, for hospitals that qualify for an adjustment to their FTE caps for residents training in new programs under § 413.86(g)(6), primary care and obstetrics and gynecology residents in new programs would be added to the quotient of the primary care and obstetrics and gynecology 3-year average, and nonprimary care residents in new programs would be added to the quotient of the nonprimary care 3-year average. The sums of the respective 3-year averages and new residents would then be multiplied by the respective PRAs.

The following example illustrates the determination of direct GME payment under the proposed rolling average methodology for an existing teaching hospital with no new programs:

Example: Assume a hospital with a cost reporting period ending September 30, 1996 (beginning October 1, 1995) had 100 unweighted FTE residents and 90 weighted FTE residents. The hospital's FTE cap is 100 unweighted residents.

Step 1. In its cost reporting period beginning in FY 2000, it had 100 unweighted residents and 90 weighted residents (50 primary care and 40 nonprimary care).

• The hospital had 90 unweighted residents and 85 weighted residents (50 primary care and 35 nonprimary care) for its cost reporting period beginning in FY 2001.

• In its cost reporting period beginning in FY 2002, the hospital had 80 unweighted residents and 80 weighted residents (50 primary care and 30 nonprimary care).

Step 2. The 3-year average of weighted primary care and obstetrics and gynecology residents is (50 +50 + 50)/3 = 50. The 3-year average of weighted nonprimary care residents is (40 + 35 + 30)/3 = 35.

Step 3. Primary care: $80,000 PRA × 50 weighted primary care and obstetrics and gynecology FTEs = $4,000,000. Nonprimary care: $78,000 × 35 weighted nonprimary care FTEs = $2,730,000.

Step 4. $4,000,000 + $2,730,000 = $6,730,000.

Step 5. If the hospital's Medicare patient load for the payment cost reporting period is .20, Medicare's direct GME payment would be $6,730,000 × .20 = $1,346,000.

Whether the proposed methodology results in a payment difference for a hospital is dependent upon whether or not the number and mix (primary care and nonprimary care) of FTEs changes in a 3-year period. If the number and mix of FTEs does not change in a 3-year period, there would be no difference in a direct GME payment amount derived using the proposed methodology versus the existing methodology. For example, if a hospital has 90 weighted FTEs (50 primary care and 40 nonprimary care) in the current year and the 2 previous years (using the PRAs and the Medicare patient load from the example above), the payment amounts derived from the existing methodology and the proposed methodology would be equal.

If the number and mix of FTEs varies from year to year, there will be a difference in the results of the two methodologies. In some instances the existing methodology would result in a higher payment, and in other instances the proposed methodology would result in a higher payment. In the example above, the hospital has reduced its number of weighted residents by 5 FTEs in FYs 2001 and 2002. Calculating this hospital's direct GME payment amount using the existing methodology (using the PRAs and the Medicare patient load from the example) would result in a payment of $1,347,250, which is $1,250 more than $1,346,000, the amount calculated in the example using the proposed methodology.

In a scenario where a hospital makes larger reductions to the number of FTEs, the proposed methodology may be more beneficial. For example, using the PRAs and the Medicare patient load from the example above, assume a hospital has 90 weighted FTEs (50 primary care and 40 nonprimary care) in FY 2000, 85 weighted FTEs (50 primary care and 35 nonprimary care) in FY 2001, and 70 weighted FTEs (35 primary care and 35 nonprimary care) in FY 2002. If the proposed methodology is used, the payment amount of $1,292,050 would be calculated, which is $1,666 more than $1,290,386, the amount calculated if the existing methodology is used.

We proposed to revise § 413.86(g)(4) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. We also proposed to revise § 413.86(g)(5) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, the direct GME payment will be calculated using two separate rolling averages, one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

Comment: Two commenters asked whether or not the proposed new methodology for calculating direct GME payment using two separate rolling averages for primary care and nonprimary care residents is truly an ''alternative,'' or, if finalized, would it replace the present methodology.

Response: The proposed new methodology would *replace* the existing rolling average methodology effective for cost reporting periods beginning on or after October 1, 2001 (the effective date of this final rule). Hospitals training both primary care and nonprimary care residents would determine two separate rolling average counts; one for primary care and one for nonprimary residents.

Comment: One commenter stated: ''although the new rolling average methodology is difficult and complex, its impact on GME programs is far from clear.'' The commenter asked how much change in resident number and mix is necessary before this new methodology has an effect on payment, and stated that more examples would be helpful in determining this effect. The commenter also expressed hope that, if this change is finalized, we will revisit this issue after implementation and fully examine and analyze its impact on teaching program payment.

Response: As we explained in the proposed rule, whether the new methodology results in a payment difference for a hospital is dependent upon whether or not the ratio of primary care to nonprimary care FTEs changes in a 3-year period. If the ratio of the FTEs does not change over the 3-year period, there would be no difference in a direct GME payment amount derived using the new methodology versus the existing methodology. In particular, there would be an increase in direct GME payment under the revised methodology, where a hospital's proportion of primary care residents to nonprimary care residents over the last 3 years is higher than the hospital's proportion of primary care residents to nonprimary care residents in the current year. As this new rolling average methodology is implemented, we intend to evaluate hospitals' direct GME payments to further analyze the impact of using this methodology.

Comment: One commenter asked how many hospitals would still be ''at risk''

for changes in payment because they retain different primary care and nonprimary care PRAs, given the implementation of the 85 percent floor.

Response: As described in the impact section of this final rule in Appendix A, we estimated that, of 1,231 teaching hospitals included in the analysis, approximately 562 hospitals have PRAs that will be increased to equal 85 percent of the national average PRA. This leaves 669 hospitals with PRAs that exceed the 85 percent floor. However, not all of these hospitals will be using the new methodology because not all of them have both primary care and nonprimary care PRAs.

Comment: One commenter noted that, in order to implement the new rolling average methodology, significant changes must be made to Worksheet E, Part A, the worksheet on the Medicare cost report used for calculating a hospital's IME adjustment. The commenter also stated that past cost reports using the current cost reporting forms would have to be reopened.

Response: As we explained in the preamble to the proposed rule and above in this final rule, we have decided to institute a separate rolling average for primary care and nonprimary care residents due to an issue with respect to the current payment methodology for *direct GME only*. That is, when combining a hospital's primary care PRA and nonprimary care PRA on Worksheet E–3, Part IV of the Medicare cost report, we currently weight the respective PRAs by *current* year residents. As a result, although Congress provided that the direct GME payments should be made based on a 3-year rolling average count of weighted residents, the current methodology introduces the number of residents that a hospital is training in the *current cost reporting period* into the payment formula. A payment formula that incorporates the number of current year residents ''dilutes'' the effect of the rolling average as related to direct GME payments. However, in regard to the IME payments, we also noted that, although they are also based on a rolling average, no change in the existing methodology is needed because there is no distinction between primary care and nonprimary care residents for IME payment purposes. Therefore, while two separate rolling averages will be used for direct GME payments (one for primary care and one for nonprimary care), a single rolling average will continue to be used for IME payments under the existing methodology. We will make the necessary changes to the Medicare cost report on Worksheet E–3, Part IV, which is used for calculating a hospital's direct GME payment, to accommodate two separate rolling average calculations.

The commenter also stated that affected cost reports in which the current rolling average methodology was used would need to be reopened. However, the effective date of this change in the methodology is *prospective,* and will only affect cost reporting periods beginning on or after October 1, 2001. We will not be reopening past cost reports to change direct GME payment because of the new methodology.

Comment: One commenter indicated that the separation of the 3-year rolling average between primary care and nonprimary care FTEs will be difficult because the prior year FTEs were not separated into primary care and nonprimary care FTEs. The commenter asked how a provider could obtain the information from prior years if the same methodology was not used.

Response: We do not believe it will be difficult for a hospital to obtain the weighted FTE counts of its primary care and nonprimary care residents separately. This is because, in fact, although the rolling average was computed based on total residents, there are lines on Worksheet E–3, Part IV (lines 3.07 and 3.08) in which the current year weighted count of primary care and nonprimary care residents are reported separately. Therefore, the hospital and the fiscal intermediary can easily refer to these lines on prior year cost reports to determine a 3-year average for primary care and nonprimary care residents, respectively.

4. Counting Research Time as Direct and Indirect GME Costs (§§ 412.105 and 413.86)

It has come to our attention that there appears to be some confusion in the provider community as to whether the time that residents spend performing research is countable for the purposes of direct and indirect GME reimbursement. Although we did not propose to make any policy changes in the May 4 proposed rule, we did reiterate our longstanding policy regarding time that residents spend in research and proposed to incorporate this policy in the IME regulations.

Section 413.86(f) specifies that, for the purposes of determining the total number of FTE residents for the direct GME payment, residents in an approved program working in all areas of the hospital complex may be counted. Accordingly, the time the residents spend performing research as part of an approved program anywhere in the hospital complex may be counted for direct GME payment purposes. If the requirements listed at §§ 413.86(f)(3) and (f)(4) are met, a hospital may also count the time residents spend doing research in nonhospital settings for direct GME payment.

For purposes of determining the IME payment, § 412.105(f)(1)(ii) specifies that the time residents spend training in parts of the hospital that are subject to the inpatient prospective payment system, in the outpatient departments, or (effective on or after October 1, 1997, in accordance with § 413.86(f)(3) or (f)(4), as applicable) in nonhospital settings, may be counted. Section 2405.3.F.2. of the Provider Reimbursement Manual (PRM) further states that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. Resident time spent ''exclusively'' in research means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. Therefore, although the research component may be part of an approved program, *the time that residents devote specifically to performing research that is not related to delivering patient care,* whether it occurs in the hospital complex or in non-hospital settings, *may not be counted for IME payment purposes.* ''Exclusively research'' time is not allowable for IME purposes irrespective of whether the resident is engaged only in research or spends only part of his or her time on research. Accordingly, time spent exclusively in research over the course of a program year should be subtracted from the total FTE count for that year. For example, if a resident is required to spend 3 months in a particular program year engaged in research activities unrelated to delivering patient care, that amount of time should be subtracted from the total FTE count, whether or not the research time is fulfilled in one block of time, or is distributed throughout the training year.

We note that in order to count residents for both direct GME and IME payment purposes, the residents' training must be part of an approved program. *This applies whether or not the residents are doing work that is clinical in nature.* There are situations where residents have completed their residency program requirements but remain for an additional period of time to continue their training (that is, to conduct research or other activities) outside the context of a formally organized approved program. As we explained in the September 29, 1989 final rule (54 FR 40306), these residents are *not* countable for direct GME or IME

reimbursement. Rather, patient care services provided by these residents should be paid as Part B services.

We proposed to amend § 412.105(f)(1)(iii) to add a paragraph (B) to incorporate language that reflects this policy.

We received several comments disagreeing with our clarification to longstanding policy on whether the time that residents spend performing research may be included in the FTE count for the purpose of determining direct and indirect GME reimbursement.

Comment: One commenter stated that the proposed revised IME regulations at § 412.105 do not mention any requirement that residents counted for purposes of the IME adjustment and assigned to a hospital's inpatient prospective payment system or outpatient area be involved in ''patient care activities.'' Instead, that requirement is only mentioned with reference to residents assigned to nonprovider settings. Therefore, the commenter believed that a patient care requirement in reference to counting residents in nonprovider settings implies the exclusion of the same requirement when counting residents in the hospital (specifically as it applies to counting research time for IME purposes).

Response: The clarification in the proposed rule addresses our longstanding interpretation of existing regulations and reflects longstanding general Medicare reimbursement principles. Under general Medicare reimbursement principles, as reflected in § 413.9, costs incurred by a hospital generally must be related to patient care in order to be reimbursed by Medicare.

The purpose of the IME payments is to address the additional costs that hospitals incur in treating patients. In our May 6, 1986 interim final rule (51 FR 16775), we stated: ''Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education computed in the same manner as the adjustments for those costs under regulations in effect as of January 1, 1983. Under those regulations, we provided that the indirect costs of medical education incurred by teaching hospitals are the increased operating costs (*that is, patient care costs*) that are associated with approved intern and resident programs'' (emphasis added). In addition, in our September 29, 1989 final rule (54 FR 40286), we specifically state: ''As used in section 1886(d)(5)(B) of the Act, 'indirect medical education' means those additional costs (*that is, patient care costs*) incurred by hospitals with graduate medical education programs. The indirect costs of medical education might, for example, include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians'' (emphasis added).

Thus, payments for IME address the additional operating costs that teaching hospitals incur in furnishing patient care. Accordingly, consistent with the purpose of IME payments and general Medicare reimbursement principles, in determining the FTE count with respect to the IME adjustment, it has been our longstanding policy that we do not include residents to the extent that the residents are not involved in furnishing patient care but are instead engaged exclusively in research.

Comment: One commenter disagreed with our use of the Provider Reimbursement Manual (PRM), section 2405.3.F.2, in support of our policy on excluding residents from the IME count if the resident is ''engaged exclusively in research.'' The commenter stated that the reference to exclusion from the resident count for residents engaged ''exclusively in research'' must be read in the context of the Manual provision, and not in a regulatory vacuum. The commenter believed that PRM section 2405.3.F.2 is addressing situations outside of the traditional residency program—where the resident time at issue is not part of an approved medical education program. The commenter believed that the phrase ''engaged exclusively in research'' refers to persons who are research scientists and not engaged in research as part of a clinical residency program.

In addition, this commenter stated that our interpretation of the word ''exclusively'' in this context is not reasonable and is contrary to the clear meaning of the term. The commenter argued that our interpretation practically eliminates the word ''exclusively,'' effectively saying that a resident is ''exclusively engaged in research'' if that resident participates in any research at all.

Response: Section 2405.3.F.2 of the PRM (published in August 1988) was written to address ''Questionable situations'' for the IME FTE count. Indeed, in the introductory paragraph in this section we state: ''It is recognized that situations arise in which it may be unclear whether an individual is counted as an intern or resident in an approved program for the purposes of the indirect medical education adjustment.'' Thus, the point of section 2405.3.F.2 of the PRM was to clarify situations for counting resident FTEs in approved programs for IME purposes. As the commenter suggested, *some* of the situations listed under this section address situations where the resident FTE time at issue is not part of the approved medical education program (for example, that a resident must not be counted for the IME adjustment if ''the individual's services in provider settings are payable as physician services (situations in which it is clear that the otherwise eligible resident is 'moonlighting')''.) (Section 2405.3.F.2. of the PRM). However, this section in the PRM was written to clarify counting rules for IME purposes in various situations. In addition to clarifying situations where resident time is spent in an unapproved program, this section in the PRM certainly also clarifies the rules for determining resident time spent in an approved program—such as time the resident is ''engaged exclusively in research'' (as cited in the proposed rule) and that ''any portion of the individual's salary is subject to reasonable compensation equivalency limits.'' (Section 2405.3.F.2. of the PRM)

Therefore, we do not agree with the commenter that we have read this manual provision in a ''regulatory vacuum''. The phrase ''engaged exclusively in research'' is *not* meant only to refer to persons who are research scientists and not engaged in research as part of an approved clinical residency program, since as explained above, there is *nothing* in the manual provision that limits the research provision to research performed outside of an approved program.

In the proposed rule, we stated that resident time spent ''exclusively'' in research ''means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital.'' (66 FR 22700). The commenter argued that this interpretation of the word ''exclusively'' in the context of the manual provision is unreasonable and contrary to the clear meaning of the term, that under our policy, a resident would be ''engaged exclusively in research'' if that resident participates in any research at all. We do not agree.

Resident time spent ''engaged exclusively in research'' means time *not* associated with the care of a particular patient (see proposed § 412.105(f)(1)(iii)(B)); thus, *any* research time that *is* associated with the treatment or diagnosis of a particular hospital patient or, effective on or after October 1, 1997, of patients in nonhospital settings, that is, usual patient care, is countable for IME payment purposes. We note that this distinction between activities that are

''usual patient care'' and research activities is, again, longstanding Medicare policy. In April 1975, at section 500 of the PRM, we stated the principle that ''Costs incurred for research purposes, over and above usual patient care, are not included as allowable costs.'' Indeed, since the inception of Medicare, we have distinguished between activities that are ''usual patient care'' and activities that are outside this scope, such as research activities.

Comment: One commenter stated that ''by its very nature as a regression analysis, or statistical measure, the IME formula is not intended to be dependent on 'the treatment or diagnosis of a particular patient of the hospital.' '' Another commenter stated: ''our understanding of the development of the adjustment is that statistical analyses showed that the use of an intern/resident-to-bed ratio (IRB) was (and continues to be) the best proxy for the patient care cost differences between teaching and non-teaching hospitals. Given that the IRB is only a proxy, the relevance of a requirement that residents themselves must be engaged in activities related to patient care in order for their training time to be counted in the IRB is unclear.''

Response: Generally, the statistical analyses used in the development of the statutory IME adjustment measured the differences between teaching and nonteaching hospitals with respect to the additional costs associated with patient care. Inpatient hospital care that involves the use of residents is costlier than inpatient hospital care that does not involve the use of residents. As the comments and the statute reflect, the hospital's ratio of interns and residents to beds is one factor in measuring the additional costs that a hospital incurs due to the use of residents in furnishing patient care. While a resident is engaged exclusively in research, the hospital is not incurring additional patient care costs due to that resident. Accordingly, we believe that the measure of additional patient care costs is more accurate if it excludes residents engaged exclusively in research.

Suppose, for example, that a teaching hospital has a total of 20 FTE residents training in prospective payment system sections of the hospital who are all involved in furnishing patient care. The amount of the IME payment to the hospital would reflect 20 FTE residents, reflecting the additional operating costs arising from the use of 20 FTE residents in furnishing patient care. Now suppose that the same hospital has the same 20 residents involved in furnishing patient care but it also has 4 additional FTE residents engaged exclusively in research. The 4 residents engaged exclusively in research do not contribute to higher operating costs and, therefore, as our longstanding policy reflects, we believe it is appropriate not to count them for purposes of the IME adjustment. Thus, in both situations, the hospital's FTE count for purposes of IME is 20. If we did make higher payments in the second situation, then the hospital would receive higher payments even though the hospital did not incur higher patient care costs.

Comment: One commenter stated that our regulations at § 413.86(e)(1)(i)(B) clearly allow research time to be counted for direct GME purposes. This commenter asserted that ''it cannot be reasonably argued that research time should be counted differently for IME than direct GME based on a new, very specific definition of patient care that applies solely to IME''. Another commenter stated the proposed rule is ''unduly burdensome'' by requiring hospitals to maintain different counts for direct GME and IME based on research activity or rotations. A third commenter stated that there is an alternative to distinguishing between direct GME and IME as it relates to research—''lawyers, often when faced with conflicting sections of the law, attempt to reconcile a common policy out of these conflicts, rather than further complicating things. You could do the same here.''

Response: As we have stated above and in the proposed rule, the clarification we made concerning the counting of FTEs for research time related to the diagnosis and treatment of a particular patient for IME purposes is *longstanding* Medicare reimbursement policy. We were *not* proposing a change in Medicare policy.

We are not introducing unnecessary complexity to the direct and indirect medical education counts, since it has *always* been Medicare policy to require the hospital to distinguish between time spent by residents involved exclusively in research and time spent on patient care. Further, the IME and direct GME FTE counts have and will continue to differ for several reasons. Hospitals have always been able to count residents in all areas of the hospital complex for direct GME but cannot count residents working in units exempt from the prospective payment system for IME. In addition, each resident included in the hospital's direct GME FTE count is counted as 0.5 FTE if they have trained beyond the number of years required to become eligible in the specialty in which they first began training. These same residents are counted as 1.0 FTE in the hospital's IME FTE count. We reiterate that we are *not* making a change in policy, but merely clarifying our policy with respect to counting residents involved in GME.

With respect to research, our policies for direct GME payment are consistent with our policies for IME payment. In both contexts, we do not pay for the costs of time spent by residents engaged exclusively in research. In making payments for IME and direct GME for a given year, it is true that we treat research *time* differently for purposes of the IME FTE count and the direct GME FTE count, but, as explained below, this difference arises from the direct GME base year methodology and does not mean that we pay for research *costs* in the direct GME payment.

In the September 29, 1989 final rule implementing the direct GME base year payment methodology, we described the calculation of the per resident amounts (PRAs). Each hospital's PRA is determined by taking the hospital's total allowable graduate medical education costs (which do not include costs allocated to the nursery cost center, *research*, and other nonreimbursable cost centers) in a base year and dividing the costs by the number of FTE residents working in all areas of the hospital complex in the base year. (§ 413.86(e)(1)(i)) In the case of research and other nonreimbursable cost centers, costs were excluded from the PRA calculation because they were nonreimbursable in the base year, consistent with longstanding Medicare policy on Medicare cost reimbursement to teaching hospitals. Ideally, residents engaged exclusively in research would also have been excluded from the base year FTE count used in the PRA calculation. However, for a number of hospitals, the FTE count for the base year *did include* residents engaged exclusively in research because the 1984 base year information available when the PRAs were determined in 1990 did not distinguish between residents involved in furnishing patient care services and residents exclusively engaged in research.

In order to avoid disadvantaging these hospitals, in making direct GME payments for a given year, we have included and continue to include residents exclusively engaged in research in the direct GME FTE count both in the base year PRA calculation and in the FTE count in subsequent payment year calculations. Doing so ''offsets'' the effects of the inclusion of such residents in the direct GME base year FTE count (no such ''offset'' is necessary in the context of IME). However, because the *costs* were

excluded in calculating the PRA, the end result is that the direct GME payment does *not* encompass the costs of residents engaged exclusively in research. Therefore, as with the IME payment, Medicare is not and has not been reimbursing teaching hospitals under direct GME for costs the hospital incurs associated with resident time spent in research unrelated to usual patient care.

Comment: One commenter stated that our policy on counting research time is well stated and clear. However, this commenter stated that there is much research that is done outside any funding source, but is an essential part of the resident's training. The commenter further stated that the hospital does assume these costs, and they are not part of the direct GME component, and so represent valid hospital expenditures due to the presence of residents.

Response: We certainly acknowledge that hospitals incur research costs associated with the training of interns and residents. We understand that many specialties require a research component to be completed as part of the specialties' board eligibility requirements. The question as far as IME payments are concerned is whether or not the research is associated with the diagnosis and treatment of a particular patient. As explained above, teaching hospitals receive Medicare IME payments to pay hospitals for Medicare's share of the additional costs these hospitals incur associated with patient care costs; if the research is not associated with usual patient care costs, then the resident research time is not reimbursable.

Comment: Two commenters stated that they are concerned that clarifications on the exclusion of resident FTEs from the IME payment for trainees engaged in activities that are purely research would be extended to include those individuals in an approved program that requires research activities at the same time as the delivery of patient care.

Response: As stated above, where the residents are engaged exclusively in research, it is appropriate to exclude that time from the IME payment calculation. However, consistent with longstanding policy, in the situation where residents are in an approved program participating in research activities that are associated with the diagnosis and treatment of a particular patient, we believe it is appropriate to include that time in the IME payment calculation.

5. Temporary Adjustments to FTE Cap to Reflect Residents Affected by Residency Program Closure

In the July 30, 1999 hospital inpatient prospective payment system final rule (64 FR 41522), we indicated that we would allow a temporary adjustment to a hospital's FTE resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital's closure. We made this change because hospitals had indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. When we proposed this change 2 years ago, we received several comments suggesting that we include lost accreditation of a program (that is, a program's closure) in the temporary adjustment policy. We explained in our response to these comments (64 FR 41522) that we did not believe it was appropriate to expand our policy to cover any acts other than a hospital's closure. We made this decision because, unless the hospital terminates its Medicare agreement, the hospital would retain its statutory FTE cap and could affiliate with other hospitals to enable the residents to finish their training.

It has come to our attention that, despite a hospital's ability to affiliate with other hospitals when it shuts down a residency program, some hospitals for various reasons do not affiliate before their programs close, particularly when the program closes abruptly towards the end of the program year (the deadline to submit Medicare affiliation agreements is July 1 of the upcoming program year). Therefore, in the May 4 proposed rule, we proposed that if a hospital that closes its residency training program agrees to temporarily reduce its FTE cap, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the former hospital's residency training program. For purposes of this policy on closed programs, we proposed to define ''closure of a hospital residency training program'' as when the hospital ceases to offer training for residents in a particular approved medical residency training program (proposed § 413.86(g)(8)(i)(B)). The methodology for adjusting the caps for the ''receiving hospital'' and the ''hospital that closed its program'' is described below.

a. *Receiving hospital.* We proposed that a hospital(s) may receive a temporary adjustment to its (or their) FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

- The hospital is training additional residents from the residency training program of a hospital that closed its program; and
- No later that 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE cap reduction statement by the hospital closing the program, as specified in paragraph (g)(8)(iii)(B)(2).

In general, the proposed temporary adjustment criteria are reflective of the temporary adjustment criteria for taking on the training of displaced residents from closed hospitals. We note that we proposed that more than one hospital would be eligible to apply for the temporary adjustment, because residents from one closed program may go to different hospitals, or they may finish their training at more than one hospital. We also noted that only to the extent a hospital would exceed its FTE cap by training displaced residents would it be eligible for the temporary adjustment.

Finally, we proposed that hospitals that meet the proposed criteria would be eligible to receive temporary adjustments (for cost reporting periods beginning on or after October 1, 2001, for direct GME and with discharges beginning on or after October 1, 2001 for IME) for training the displaced residents from programs that closed even before the effective date of this policy. We mentioned this because hospitals may have closed programs in the recent past and the residents from the closed programs may not have completed their training as of the effective date of this policy. For instance, if a 5-year residency program, such as surgery, closed on July 1, 1997, the 5th program year residents may still be training during this residency year (2001). We proposed that if both the receiving hospital(s) and the hospital that closed the program in this example follow the criteria described in this preamble, the receiving hospital may receive a temporary adjustment to its FTE cap for 9 months (October 1, 2001 through June 30, 2002) to accommodate the 5th year surgery residents. However, we noted that hospitals would not be eligible to receive a temporary adjustment for

training the residents until the effective date of this rule (that is, October 1, 2001).

b. *Hospital that closed its program(s).* We proposed that a hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program(s)—

- Temporarily reduces its FTE cap by the number of FTE residents in each program year training in the program at the time of the program s closure. The yearly reduction would be determined by deducting the number of those residents who would have been training in the program year during each year had the program not closed; and
- No later than 60 days after the residents who were in the closed program begin training at another hospital, submits to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

Unlike the closed hospital policy at § 413.86(g)(8), we proposed under this closed program policy (which we proposed to amend § 413.86(g)(8) to include), that in order for the receiving hospital(s) to qualify for a temporary adjustment to its FTE cap, the hospitals that are closing their programs would need to reduce their FTE cap for the duration of time the displaced residents would need to finish their training. We proposed this change because, as explained below, the hospital that closes the program still has the FTE slots in its cap, even if the hospital chooses not to fill the slots with residents. We believe it is inappropriate to allow an increase to the receiving hospital's cap without an attendant temporary decrease to the cap of the hospital with the closed program, even if the increase is only temporary. We noted that even under the proposed closed program policy, the hospital that closes its program may choose instead to affiliate with another hospital by July 1 of the next residency year so that the residents can more easily finish their training.

We proposed that the cap reduction for the hospital with the closed program would be based on the number of FTE residents in each program year who were in the program at the program's closure, and who began training at another hospital, rather than the count of residents each year at the hospital(s) receiving the temporary adjustment(s). We believe it would be too burdensome administratively to require the hospital closing the program to keep track of the status of the residents when they are training at other hospitals. For instance, Joe Smith, a resident who is a PGY 1 when Hospital X closes its pathology residency program, may then finish his training at Hospital Y. The resident trains for one year at Hospital Y as a PGY 2, but decides to drop out of the program before finishing. It would be burdensome to require Hospital X to keep track of Joe Smith's status while he is training at Hospital Y for purposes of the reduction in Hospital X's cap. Therefore, we proposed to ''freeze'' the basis for the reduction of the FTE cap of the hospital that closed the program based on the count and status of the residents when the hospital closes the program.

Example: Hospital A, which has a direct GME FTE cap of 20 FTEs and an IME FTE cap of 18 FTEs, is experiencing financial difficulties and decides to close down its internal medicine residency training program effective June 30, 2002. As of June 30, 2002, Hospital A is training 2 PGY 1s, 4 PGY 2s, and 6 PGY 3s in its internal medicine program. Hospitals B, C, and D take on the training of the displaced residents. These hospitals are eligible to receive temporary adjustments to their FTE caps if they follow the proposed criteria stated above. In order for Hospitals B, C, and D to receive the temporary adjustments, however, Hospital A must agree to reduce its FTE cap. According to the proposed criteria stated above, Hospital A's reduction would be:

July 1, 2002 through June 30, 2003

Direct GME FTE cap: 14 FTEs, (20 FTEs cap—2 PGY 2s–4 PGY 3s)
IME FTE cap: 12 FTEs (18 FTEs–2 PGY 2s–4 PGY 3s)

We note that no downward adjustment for the 6 PGY 3s for either cap is necessary since these residents will have completed their training in that program by the July 1, 2000 through June 30, 2003 program year.

July 1, 2003 through June 30, 2004

Direct GME FTE cap: 18 FTEs (20 FTEs cap—2 PGY 3s)
IME FTE cap: 16 FTEs (18 FTEs cap—2 PGY 3s)

July 1, 2004 through June 30, 2005

Direct GME FTE cap: 20 FTEs
IME FTE cap: 18 FTEs

We also proposed to revise § 412.105(f)(1)(ix) to make the provision relating to the adjustment to FTE caps to reflect residents affected by closure of hospitals' medical residency training programs applicable to determining the IME payment.

Comment: Several commenters commended us for extending payment of IME and direct GME to situations of program closure, explaining that this change will help stabilize the GME system and ensure that residents can continue their training without imposing financial hardship on the institutions that accept them into their programs. One commenter also noted that the tradeoff in the FTE resident cap between a hospital closing its residency program and the hospital receiving the displaced residents seems reasonable. Another commenter stated that while the proposed rule more than adequately described the requirements and procedures for allowing a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital's program, the receiving hospital is penalized because the 3-year rolling average applies to these residents. The commenter noted that, in the first and second year, the receiving hospital will be paid one third and two thirds of the costs of these displaced FTE residents because of the rolling average, although the receiving hospital is paying for these FTE residents at full cost. The commenter suggested that a temporary exception should be granted to receiving hospitals from the 3-year rolling average in the same manner as residents in new programs under § 413.86(g)(5) are excluded from the rolling average. The commenter also asked that temporary relief should be granted in the IME adjustment with regard to the application of the resident-to-bed ratio cap, wherein the relief from this cap should be an adjustment to the prior year's resident FTEs equal to the increase in the current year's FTEs which is attributable to the transferred residents.

Response: We understand the commenter's concern regarding the inclusion of the resident FTEs displaced by the closure of another hospital's program in the receiving hospital's rolling average count of residents, for both direct GME and IME purposes. In addition, we believe that a similar concern also exists in regard to the inclusion of residents in the receiving hospital's rolling average calculation for residents displaced by the closure of another hospital. Therefore, we are revising proposed § 412.105(f)(1)(v) for IME and adding a paragraph (vi) to proposed § 413.86(g)(5) for direct GME to specify that FTE residents that are displaced by the closure of either another hospital or another hospital's program are added after the calculation of the rolling average for the receiving

hospital for the duration of time that those displaced FTE residents are training at the receiving hospital.

In regard to providing temporary relief to the receiving hospital's IME resident-to-bed ratio cap for the displaced residents, while we understand the commenter's concern about this issue as well, at this time we have decided not to allow the exclusion of these displaced residents in applying the resident-to-bed ratio cap. Under existing IME policy, the receiving hospital may be held to a lower cap in the first year of training the displaced residents. However, the receiving hospital may benefit from the higher cap in the year following the final year of the displaced residents' training. Effective in the first year that the receiving hospital takes on the displaced residents, it will be capped by the prior year's lower resident-to-bed ratio because the displaced residents will not be included in the prior year FTE count. However, an increase in the current year's ratio will establish a higher cap for the following year. Furthermore, in the last year that the receiving hospital is training the displaced residents, a higher cap will be established for the following year in which all the displaced residents will have left the hospital since they have completed their training. Therefore, we believe it is unnecessary to exclude displaced residents in applying the resident-to-bed ratio cap. While we are not making any changes to address this issue at this time, we will consider suggestions for possible changes in the future, if warranted.

Comment: One commenter stated that it is unclear at what rate the payments for IME and direct GME will be made for the hospital receiving the displaced residents. The commenter asked if Medicare would pay that hospital at the same rate that the hospital with the closed program was paid for its residents, or would the receiving hospital receive Medicare payment at the same rate it currently is paid.

Response: The receiving hospital will receive payment for the displaced residents using its own rates—that is, the same rates as those used for residents in its own programs. The receiving hospital will use its own bed count for IME payment purposes, and its own PRA and Medicare patient load for direct GME payment purposes.

Comment: One commenter stated that, although the commenter supports the proposal for allowing temporary adjustments for residents coming from a closed program, the commenter believed that a mechanism should be established to ''permanently preserve resident positions, as opposed to individual residents,'' so long as there is no increase in the total number of FTE residents for which Medicare payment is made.

Response: In proposing § 413.86(g)(8)(iii), which allows a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital's program, we have attempted to make these regulations consistent with the existing regulations at § 413.86(g)(8). These existing regulations allow a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital. Therefore, because the regulations only allow for a temporary cap adjustment in situations involving hospital closure, we believe that it is appropriate to only allow for a temporary adjustment in situations involving program closure, as well.

6. Conforming Change to Regulations Governing Payment to Federally Qualified Health Centers (§ 405.2468(f))

We have discovered a technical error in the regulations at § 405.2468(f) regarding payment to federally qualified health centers (FQHCs) and rural health centers (RHCs) for the costs of graduate medical education. Specifically, § 405.2468(f)(6)(ii)(D) provides that ''The costs associated with activities described in § 413.85(d) of this chapter'' are not allowable graduate medical education costs. We recently amended § 413.85 in a final rule (66 FR 3358, January 12, 2001) regarding Medicare pass-through payment for approved nursing and allied health education programs. However, we inadvertently did not make a conforming change to § 405.2468(f)(6)(ii)(D). Section 405.2468(f)(6)(ii)(D) should read ''The costs associated with activities described in § 413.85(h) of this chapter.'' We proposed to revise § 405.2468(f)(6)(ii)(D) to reflect this change.

7. Provisions of the August 1, 2000 Interim Final Rule With Comment Period

The following provisions were included in the August 1, 2000 interim final rule with comment period. We are presenting a discussion of these provisions here in order to respond to the public comments received on the provisions and to finalize the rule.

Section 1886(h) of the Act, as revised by Public Law 105–33, caps the number of residents a hospital may count for direct GME and IME. In general, the total number of residents in the fields of allopathic or osteopathic medicine in a hospital may not exceed the number of such FTE residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. In the regulations we published on August 29, 1997 (62 FR 46003), May 12, 1998 (63 FR 26327), July 31, 1998 (63 FR 40986), and July 30, 1999 (64 FR 41517), we established special rules for adjusting the FTE resident caps for indirect and direct GME for new medical residency programs. Public Law 106–113 further revised sections 1886(d) and 1886(h) of the Act to allow a hospital's caps to be adjusted if certain additional criteria are met.

a. Counting Primary Care Residents on Certain Approved Leaves of Absence in Base-Year FTE Count (Section 407(a)(1) of Public Law 106–113 and New 42 CFR 412.105(f)(1)(xi) and 413.86(g)(9))

The limit that was placed on the number of residents that a hospital may count for purposes of direct GME and IME is based on the number of residents in the hospital's most recent cost reporting period ending on or before December 31, 1996. In the situation where a primary care resident was previously training in a hospital's residency program, but was on an approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996, the hospital's FTE cap may be lower than it would have been had the resident not been on an approved leave of absence. Section 407(a) of Public Law 106–113 amended section 1886(h)(4)(F) of the Act to direct the Secretary to count an individual for purposes of determining a hospital's FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence.

The statute allows a hospital to receive an adjustment for those residents to its individual FTE cap of up to three additional FTE residents. We provided that, in order for a hospital to receive this adjustment, the leave of absence must have been approved by the residency program director to allow the residents to be absent from the program and return to the program after the absence. We required that no later than 6 months after the date of publication of this interim final rule, the hospital must submit a request to the fiscal intermediary for an adjustment to its FTE cap and must provide contemporaneous documentation of the approval of the leave of absence by the residency program director, specific to

each additional resident that is to be counted for purposes of the adjustment. For example, a letter to the resident by the residency program director before the resident takes the leave would be sufficient documentation of prior approval of the leave of absence.

Under section 407(a)(3) of Public Law 106–113, this provision is effective for direct GME FTE counts with cost reporting periods beginning on or after November 29, 1999, and for IME FTE counts, with discharges occurring in cost reporting periods beginning on or after November 29, 1999.

We added §§ 412.105(f)(1)(xi) and 413.86(g)(9) to our regulations to incorporate the provisions of section 407(a) of Public Law 106–113.

We received one comment concerning section 407(a)(1) of Public Law 106–113, as implemented at §§ 412.105(f)(1)(xi) and 413.86(g)(9), concerning the counting of primary care residents in certain approved leaves of absence in base-year FTE counts.

Comment: One commenter asked us to consider allowing hospitals to count FTE residents for residents who had been training in an approved residency program at a hospital but then left the hospital during the 1996 base-year and never returned. The commenter stated that the FTE slot in which the ''abandoning'' resident vacated sometime in 1996 was filled by another resident in 1997 and thereafter, but the hospital has never received any direct or indirect GME payment for this FTE slot.

Response: Section 407(a) of Public Law 106–113 amended section 1886(h)(4)(F) of the Act to direct the Secretary to count an individual for purposes of determining a hospital's FTE cap to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual ''was on maternity or disability leave or a similar approved leave of absence.'' We believe that this provision was *not* intended to apply to residents who leave the program in the base-year and never return. The statutory language is quite clear that in order for a hospital to count residents in this provision, the resident must have been on an ''approved leave of absence.'' A ''leave of absence'' necessarily translates to a resident being away and then *returning* to the hospital at which the resident had been training.

b. Adjustments to the FTE Cap for Rural Hospitals (Section 407(b)(1) of Public Law 106–113 and 42 CFR 412.105(f)(l)(iv) and 413.86(g)(4))

Public Law 105–33 included several provisions with the intent of encouraging physician training and practice in rural areas. Section 1886(h)(4)(H)(i) of the Act, as added by section 4623 of Public Law 105–33, directed the Secretary, in promulgating rules for the purpose of the FTE cap, to give special consideration to facilities that meet the needs of underserved rural areas. Consistent with the intent of this provision, section 407(b) of Public Law 106–113 provides a 30-percent expansion of a rural hospital's direct and indirect FTE count for purposes of establishing the hospital's individual FTE cap. Specifically, section 407(b) provided that, effective for direct GME with cost reporting periods beginning on or after April 1, 2000, and for IME, with discharges occurring on or after April 1, 2000, the FTE count may equal 130 percent of the number of unweighted residents the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996.

For example, if a hospital located in a rural area had 10 unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision the hospital would have a FTE cap of 13 unweighted FTEs, instead of 10 unweighted FTEs, because the hospital is located in a rural area. The revised FTE cap is equal to 130 percent of the number of unweighted residents in its most recent cost reporting period ending on or before December 31, 1996. The rural hospital's new FTE cap, effective April 1, 2000, is now 13 FTEs. However, if a hospital located in a rural area had zero unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision, this hospital would receive no adjustment to its FTE cap (130 percent of zero is zero FTEs).

We incorporated the provision of section 407(b) of Public Law 106–113 in §§ 412.105(f)(1)(iv) and 413.86(g)(4). We did not receive any comments on this provision.

c. Rural Track FTE Limitation for Purposes of GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area (Section 407(c) of Public Law 106–113 and new 42 CFR 412.105(f)(1)(x) and 413.86(g)(11))

In order to encourage the training of physicians in rural areas, section 407(c) of Public Law 106–113 amended section 1886(h)(4)(H) of the Act to add a provision that in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment may be made to the hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April l, 2000.

Section 407(c) of Public Law 106–113 did not define ''rural tracks'' or an ''integrated rural track,'' nor are these terms defined elsewhere in the Social Security Act or in any applicable Federal regulations. Currently, there are a number of accredited residency programs, particularly 3-year primary care residency programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility. These separately accredited ''rural track'' programs are identified by the Accreditation Council of Graduate Medical Education (ACGME) as ''1–2'' rural track programs. Accordingly, we implemented section 407(c) to address these ''1–2'' programs. In addition, we implemented section 407(c) to account for other programs that are not ''1–2'' programs but which include rural training portions.

As stated above, since there is no existing definition of ''rural track'' or ''integrated rural track,'' we defined at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or to a rural nonhospital site(s). We noted that ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

We amended § 413.86 to add paragraph (g)(11) (and amended § 412.105 to add paragraph (f)(1)(x)) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, (or, for IME, for discharges occurring on or after April 1, 2000), an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). An urban hospital may count the residents in the rural track up to a ''rural track FTE limitation'' for that

hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents training in a rural track residency program that an urban hospital may include in its FTE count, that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: Rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. These two categories are then subdivided according to where the residents are training in the rural area; the residents may be trained in a rural hospital or the residents may be trained in a rural nonhospital site. To account for rural track residency programs with rural rotations that have program lengths greater than or less than 3 years, or that are not ''1–2'' programs, we specified ''two-thirds of the length of the program,'' instead of ''2 out of 3 program years,'' as a qualification to count FTEs in the rural track.

In the interim final rule with comment period, we specified that urban hospitals that wish to count FTE residents in rural tracks, up to a rural track FTE limitation, must comply with the conditions discussed below:

(1) Rotating Residents for at Least Two-Thirds of the Program to a Rural Hospital(s)

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(i) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program; and (2) the number of years those residents are training at the urban hospital.

We utilized the term ''designated'' at § 413.86(g)(11)(i) (as well as at §§ 413.86(g)(11)(ii) and (iv)) to refer to the calculation of the rural track FTE limitation. ''Designated'' means that the residents must actually have enrolled in that rural track program to rotate for a portion of the rural track program to a rural area (either rural hospital(s) or rural nonhospital site(s)). To be counted as an FTE in this first scenario, these enrolled residents must actually rotate for at least two-thirds of the duration of the program to a rural hospital(s). If a resident, at the beginning of his or her training, intends to train in the rural area for at least two-thirds of the duration of the program, but ultimately never does so, this resident would be proportionately excluded from the urban hospital's rural track FTE limitation.

We noted that if the residents in the rural track are rotating to a rural hospital(s), the rural hospital(s) may be eligible to count the residents as part of its FTE count. If the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track for the time those residents are training at the rural hospital(s), in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may be eligible to count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended in the interim final rule with comment period to implement section 407(b)(1) of Public Law 106–113.

(2) Rotating Residents for at Least Two-Thirds of the Program to a Rural Nonhospital Site

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(ii) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital and the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program and the rural nonhospital site(s); and,(2) the number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

We note that we specified at § 413.86(g)(11)(ii) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under existing § 413.86(f)(4). Section 413.86(f)(4) provides, in part, that a hospital that incurs ''all or substantially all'' of the costs of training residents in a nonhospital site may include those residents in determining the number of FTE residents (not to exceed the FTE cap) for that hospital. Under this rural track policy, where the urban hospital rotates residents for at least two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4). In the August 1, 2000 interim final rule with comment period (66 FR 47034), we included an example of application of this policy.

(3) Rotating Residents for Less Than Two-Thirds of the Program to a Rural Hospital(s)

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(iii) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may not include those residents in its FTE count, nor may the urban hospital include those residents as part of its rural track FTE

limitation. However, we noted that, in this scenario, if the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track, in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended, to incorporate the provisions of section 407(b)(1) of Public Law 106–113.

We are not permitting an urban hospital to count the time of residents training at the urban hospital in a rural track rotating to a rural hospital(s) for less than two-thirds the duration of the program (either as part of the urban hospital's FTE count or as part of its rural track FTE limitation), because to do so would inappropriately allow the urban hospital to circumvent the FTE caps by creating a new program with minimal training in a rural track. However, in this situation, like the other three provisions that concern the training of residents in rural areas, we indicated that we will allow Medicare payment for the rural portion of the training to the rural hospital.

(4) Rotating Residents for Less Than Two-Thirds of the Program to a Rural Nonhospital Site

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(iv) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents training in the rural track at the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s); and (b) the length of time in which the residents are being trained at the rural nonhospital site(s).

We noted that, in this situation, an urban hospital would not be able to count the FTE for the rural track resident while the resident is training at the urban hospital. The rural track FTE count and the rural track FTE limitation for the urban hospital would be limited to account for the residents training at the rural nonhospital site.

As in the second scenario at § 413.86(g)(11)(ii), we specified at § 413.86(g)(11)(iv) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under § 413.86(f)(4). Under the rural track policy, where the urban hospital rotates residents for less than two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4).

We noted that, in this last scenario, we are allowing the urban hospital to receive a rural track FTE limitation even in situations where it is rotating residents to a rural area for a minimal period of time (less than two-thirds the duration of the program). However, we believe that this last scenario can be distinguished from the third scenario in which the urban hospital is again rotating residents to a rural area for a minimal portion of the program but to a rural hospital instead of a rural nonhospital site. In the third scenario, we allow Medicare payment to go to the rural hospital for the portion of the urban hospital program that involves rural training (but not to the urban hospital, if the rural hospital is receiving an FTE cap adjustment for that training). However, in the last scenario, we allow the urban hospital to include the rural track residents in its FTE count (and as part of its rural track FTE limitation), based on how long it rotates the residents to the rural nonhospital site (and also incurs all or substantially all of the training costs). We do not believe that the urban hospital can circumvent its FTE cap in this last scenario because it will only count the rural track residents based on the portion of training in the rural nonhospital site. In the interim final rule with comment period (66 FR 47035), we included an example of the last scenario.

(5) Conditions That Apply to All Urban Hospitals

In the August 1, 2000 interim final rule with comment period, we specified that all urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitations, must also comply with each of the following conditions, as stated at §§ 413.86(g)(11)(v) and (vi):

- A hospital may not include in its FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap (if the rural track program was in existence during the hospital's most recent cost reporting period ending on or before FY 1996).
- A hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the urban hospital intends to rotate for a portion of the residency program to a rural area. For example, written contemporaneous documentation might be a letter of intent signed and dated by the rural track residency program director and the resident at the time of the resident's entrance into the rural track program as a PGY 1.
- All residents who are included by the hospital as part of its FTE count (not to exceed its rural track FTE limitation) must ultimately train in the rural area.
- If we find that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, we will reopen the urban hospital's cost report within the 3-year reopening period (as specified in § 405.1885) and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

We received several comments regarding the provisions of section 407 of Public Law 106–113 implemented in the August 1, 2000 interim final rule with comment period.

Comment: One commenter cited studies that found that more than half of residents with as little as 3 months of rural training became rural physicians, and, therefore, to best serve the intent of the legislation and significantly increase the number of rural physicians, we should fully fund FTEs with less than two-thirds total training in rural areas.

Response: Section 1886(h)(4)(H)(iv) of the Act, as added by section 407(c) of Public Law 106–113, provides for adjustments to the FTE cap ''[i]n the case of a hospital that is not located in a rural area but establishes *separately accredited* approved medical residency training programs (or rural tracks) in a[]

rural area * * *.'' Thus, in order for a hospital to receive an adjustment under this provision, the training program must be *separately accredited.* The ACGME has established criteria to separately accredit programs that involve training in rural areas; under these criteria, a training program may be separately accredited if residents in the program train for at least 2 years of the 3-year program at a rural facility. Currently, the ACGME does *not* separately accredit a program as a rural track program or a program in a rural area unless it meets this ''1–2'' condition. We make an adjustment to the FTE cap under the rural track provision only if a program is separately accredited, and in order to be separately accredited, the program must meet ACGME's ''1–2'' criteria. We are amending the regulations at § 413.86 by adding paragraph (g)(11) to reflect this policy .

Furthermore, we believe that incorporating the ACGME's criteria reasonably identifies the situations in which an adjustment to the FTE cap under the rural track provision is warranted. We believe that it is important to limit adjustments under this provision to situations in which residents receive a significant amount of training in rural areas. While we certainly agree that post-residency physician retention in rural areas is important, we believe that it is also important to prevent hospitals from receiving adjustments to the FTE cap in situations when an adjustment is not warranted. We believe that, if an urban hospital could receive an adjustment to its FTE cap by providing only a nominal amount of training in a rural area, then hospitals might be able to inappropriately circumvent the FTE caps. Thus, our policy reflects the requirements of the statute as well as a balancing of considerations (permitting adjustments for hospitals that establish programs that provide a significant amount of training in rural areas, and preventing adjustments for hospitals that do not warrant an adjustment).

Comment: One commenter noted that, for cost reporting periods beginning on or after April 1, 2000, section 407 of Public Law 106–113 allows rural hospitals to increase their FTE resident caps by 30 percent and urban hospitals with rural training tracks to count those residents in rural tracks. The commenter had two concerns: (1) What happens to rural track programs that were in existence between January 1, 1997 and April 1, 2000; and (2) if the intent of the rural track provision is to encourage training in rural areas, then rural track programs in existence between January 1, 1997 and April 1, 2000 should also be permitted to expand by 30 percent.

Response: Section 1886(h)(4)(F) of the Act, as added by section 407(b) of Public Law 106–113, and as implemented at §§ 413.86(g)(4) and 412.105(f)(1)(iv), provides for a 30-percent expansion to a *rural* hospital's direct and indirect FTE counts for purposes of establishing the hospital's individual FTE cap. Section 407(c) provides for an adjustment to the FTE cap of *urban* hospitals for training residents in rural areas. Section 407(b) clearly only applies to *rural* hospitals, and not to urban hospitals, regardless of whether or not the urban hospitals train residents in rural areas. Therefore, while the general intent of the provisions at section 407 is to encourage training in rural areas, only those rural hospitals that have a FTE resident cap based on the count of residents in the hospital's cost reporting period ending on or before December 31, 1996, may qualify for a 30-percent increase to that FTE cap under the amendments made by section 407(b).

To address the commenter's uncertainty concerning what happens to rural track programs that were in existence between January 1, 1997 and April 1, 2000, we point to our language at §§ 413.86(g)(11) and 412.105(f)(1)(x) which states that for cost reporting periods beginning on or after April 1, 2000, ''an urban hospital that establishes a new residency program, *or has an existing residency program,* with a rural track (or an integrated rural track) may include in its FTE count residents in those tracks * * *'' (emphasis added). Thus, urban hospitals with rural tracks that were in existence between January 1, 1997 and April 1, 2000, and continue to be in existence afterApril 1, 2000, may be eligible for Medicare payment under this provision. We note that urban hospitals with rural tracks that were established *before* January 1, 1997, and continued to exist after April 1, 2000, may be eligible for payment under this rural track provision, as well.

We note that we have received questions from the provider industry regarding the application of the rural track FTE limitation and rural track FTE count to hospitals with rural track programs that have already been in existence before April 1, 2000. Generally, the methodology at § 413.86(g)(11) states that the actual count of residents for the first 3 years of the rural track's existence is to be used as the hospital's rural track FTE limitation, and beginning with the fourth year, the rural track FTE limitation is determined based on the number of residents training in the rural track in the third year of the program's existence. However, if a rural track program has been in existence for at least 3 years prior to April 1, 2000, the provision regarding using the actual count of residents in the first 3 years of the program would not apply. Rather, for such a program, the rural track FTE limitation would take effect immediately on April 1, 2000. The limitation would be based on the highest number of residents in any program year training in the rural track in the third year of the program, depending on the amount of time the residents spent in the rural area, subject to the regulations at § 413.85(g)(11)(i) through (iv). It would be the responsibility of the hospital to provide the necessary information regarding the third year of the program to the fiscal intermediary. For example, if the third year of the rural track's existence is July 1, 1997 to June 30, 1998, the rural track FTE limitation would be based on the highest number of residents in any program year in 1997–1998 training year. The urban hospital may begin to count the additional FTEs up to its rural track FTE limitation in its cost reporting period beginning on or after April 1, 2000 for direct GME, and for discharges occurring on or after April 1, 2000 for IME.

Comment: One commenter noted that the interim final rule with comment period states that ''all residents that are included by the hospital as part of its FTE count must ultimately train in the rural area.'' The commenter expressed concern that we are requiring hospitals to designate specific *individuals,* rather than *FTEs,* and that basing payment on individuals rather than FTEs would set a poor precedent. The commenter further stated that, while specific individuals may not remain in a program, hospitals should be permitted to fill these slots with FTEs and receive payment.

Response: The commenter is concerned with the provision at § 413.86(g)(11)(v)(C), which states that all residents that are included by the hospital as part of its FTE count under this provision must ultimately train in the rural area. As the commenter correctly assesses, this particular provision would link the rural track policy to specific individual residents, rather than FTEs. We made this link to individuals rather than FTEs because we believe the additional provision at § 413.86(g)(11)(v)(C) (as well as the provision at §§ 413.86(g)(11)(v)(B)) was necessary in order to ensure that urban hospitals did not count additional FTE

residents who did not actually rotate at any time to a rural area.

However, we understand the commenter's concern about permitting hospitals to fill slots with FTEs that are open because individuals did not remain in the program. We agree that where a hospital fills a vacated FTE slot in a rural 1–2 program with another resident, it would be consistent with the intent of the rural track provision to allow the urban hospital to count the time of the resident who left the training program. Accordingly, we are amending the regulations at § 413.86(g)(11)(v)(C) to allow for the counting of the resident's time at the urban hospital where, for example, a resident who just completed her PGY1 year at the urban hospital decides to drop out of the program, and then the urban hospital fills the vacated FTE slot with another PGY2 resident who then continues and completes the rural portion of the rural track program. We note that we would *not* allow for the counting of the time at the urban hospital for the first year of training for that resident who left the program where the urban hospital fills the vacated FTE slot with another PGY1 resident who first begins to train in the urban hospital, since, in effect, this would result in double counting one FTE at the urban hospital without the required amount of training occurring in the rural area.

Comment: One commenter expressed concern with the provision at § 413.86(g)(11)(v)(A) that states ''an urban hospital may not include in its rural track FTE limitation or FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.'' The commenter stated that this provision fails to account for the fact that many hospitals may have ''backed out'' residents training time in rural sites from their base year FTE cost reports. The commenter stated further that this provision may be interpreted by cost report accountants to mean that appeals to include FTEs that were excluded by Public Law 105–33 are prohibited.

Response: We believe the commenter is confusing the provision at § 413.86(g)(11)(v)(A), that an urban hospital may not include in its rural track FTE limitation or rural track FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap, and the policy contained in section 4623 of Public Law 105–33, as implemented at §§ 412.105(f)(1)(iv) and 413.86(g)(4), which places a limit on the count of residents, or hospitals' FTE caps. The intent of the provision at § 413.86(g)(11)(v)(A) is to encourage more residency training in rural areas by providing for Medicare payment to an urban hospital for FTE residents who are training in a rural area and are not already included as part of the hospital's FTE cap. Whether or not there are many hospitals that have ''backed out'' resident training time in rural sites from their base year FTE cost reports is irrelevant to this rural track requirement. The possible mistaken exclusion of the count of resident FTEs spent in rural settings is an issue relevant to the determination of a hospital's initial FTE cap as provided for at §§ 412.105(f)(1)(iv) and 413.86(g)(4). The rural track requirement at § 413.86(g)(11)(v)(A) was not intended to provide for adjustments to reflect FTEs that were excluded from the FTE cap.

With regard to rural training, generally, and the determination of a hospital's FTE cap under §§ 412.105(f)(1)(iv) and 413.86(g)(4), a FTE resident should not have been included in the hospital's FTE cap to the extent that, in that cost reporting year, the resident was rotating to another rural hospital, or if the resident was rotating to a rural nonhospital to which the urban hospital was not paying all or substantially all of the costs of training (see § 413.86(f)(3)).

To clarify the intent of the requirement that ''an urban hospital may not include in its rural track FTE limitation or FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap,'' we are providing the following example:

- Assume there are 10 unweighted FTE residents training at an urban Hospital A in the hospital's most recent cost reporting period ending on or before December 31, 1996, thereby establishing Hospital A's FTE cap at 10.
- In July 2002, Hospital A starts a rural training track program. In addition to devoting 2 out of its 10 FTE slots to the rural track, Hospital A recruits an additional 2 FTEs to participate in the rural track, for a total of 12 FTEs to be trained in that cost reporting year.
- These 4 FTEs will complete 1 year of training at Hospital A and 2 years of training at a rural nonhospital site. This type of program is modeled after the scenario outlined at § 413.86(g)(11)(ii), where the urban hospital may include in its FTE count the FTEs in the rural track at the urban hospital and at the rural nonhospital site. (Hospital A is complying with the requirements at § 413.86(f)(4) regarding the counting of residents in nonhospital sites).

However, when calculating the rural track FTE limitation in the fourth year of the rural track's existence, Hospital A may not include in its rural track FTE limitation *those FTEs that were already included as part of the hospital's initial FTE cap.* Two of the hospital's four FTEs training in the rural track were already included in the hospital's FTE cap. Therefore, beginning July 2002, only two FTEs may be included to determine the hospital's rural track FTE limitation, as well as its rural track FTE count. Since it is the two FTEs that Hospital A added when it started the rural track that have caused the hospital to exceed its FTE cap, only two FTEs may be counted above the FTE cap for the hospital's rural track FTE count and limitation. However, we note that the other two FTEs training in the rural track that were not included as part of the hospital's *rural* FTE count and limitation because they had already been included as part of the hospital's FTE cap, may still be counted by the hospital in its *general* FTE count, according to §§ 412.105(f) and 413.86(f).

Comment: One commenter requested that, since rural hospitals often do not have the resources or infrastructure to claim their GME costs on a Medicare cost report, we should revise the regulations to allow urban hospitals to claim the resident FTEs training at the rural hospitals, as long as the urban hospitals are providing ''adequate funding'' to the rural hospital, similar to our Medicare policy on nonhospital settings.

Response: In regard to the request to allow urban hospitals to claim the FTEs training in rural hospitals, while we understand that it is not uncommon for urban hospitals to incur the costs of training residents in rural hospitals because the rural hospitals cannot incur the costs themselves, there is longstanding policy that prohibits one hospital from claiming the training time of FTEs training at another hospital. First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME computation of count of the number of FTE residents ''shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.'' Accordingly, the September 4, 1990 **Federal Register** (55 FR 36065) states that ''* * * the other hospital is required to include the portion of time the resident spent at its facility in its FTE count consistent with § 413.86(f).'' Further, the regulations at § 413.86(f)(2) state that ''No individual may be counted as more than one FTE * * *. [I]f a resident spends time in more than one hospital * * * the

resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked * * *.'' Therefore, even though the urban hospital incurs the training costs and the rural hospital does not claim the FTEs for Medicare direct GME and IME payment purposes, the urban hospital is precluded from claiming any FTEs training at the rural hospital (or any other hospital, for that matter). The commenter is correct in stating that a hospital may count the time residents spend in *nonhospital* settings if they comply with the criteria at § 413.86(f)(4). However, this regulation implements *statutory* provisions (sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act), which specifically provide for Medicare direct GME and IME payment to be made to hospitals for training residents in nonhospital settings.

Comment: One commenter objected to the policy in the interim final rule with comment period that the terms ''rural track'' and ''integrated rural track'' are synonymous. The commenter (a hospital) believed that we have the authority to develop a new definition for ''integrated rural track'' based on our interpretations of congressional intent, and we should not wait for further clarification from Congress at the expense of the commenter's particular allopathic family practice residency program. The commenter described this program as one in which the residents train in the rural setting for approximately 7 months out of a 3-year program, and for the remainder of the program when the residents spend training in the urban setting, the residents treat rural patients. The commenter proposed the following new definition for integrated rural track: ''*Accredited Training Program with an Integrated Rural Track*—refers to an accredited program that provides at least 6 months of training at a rural location in addition to 2 years of rural training at an urban location. The 6 months of rural training should be conducted as part of all 3 years of training. The program should also establish a continuity of care with patients in a rural area for at least one program year.''

Response: When we implemented this provision on August 1, 2000, we did so based on discussions with the Accreditation Council for Graduate Medical Education (ACGME), which accredits rural track programs. The ACGME specifically identifies and separately accredits programs with 1 year of training in an urban hospital and 2 years of training in a rural facility as ''rural tracks.'' However, the ACGME explained that it did not have a separate definition of ''integrated rural track'' and, in particular, did not separately classify programs with portions of rural training of less than 2 years as ''integrated rural tracks''. In response to questions raised on this provision, we have followed up with the ACGME to confirm whether a definition of, or criteria for identifying programs with, ''integrated rural tracks'' had been established. We were informed that the term ''integrated rural track'' is not, and never was, a term that is used by the ACGME in accrediting its programs. Other than the 1–2 programs that specifically incorporate 2 years of rural training, the ACGME does not grant unique accreditation to programs with a rural focus, nor do any of the other accreditation organizations listed at § 415.152.

In addition, we do not believe it is administratively feasible for us to review documentation and confirm that the training at the urban hospital, as suggested by the commenter, is rural in nature, based on the patient load treated by the residents at the urban hospital. We currently do not have a way of tying patient data to the residents that treat them. Accordingly, for purposes of this policy, until we believe we can appropriately categorize and define rural tracks and integrated rural tracks separately, we will continue to define these terms synonymously. We remain open to adopting another definition of a separately accredited training program, and we welcome suggestions for definitions that would be administratively feasible to apply.

Comment: One commenter suggested that we add a fifth scenario to those already described at § 413.86(g)(11). The commenter proposed the following regulation text:

Rotating Residents of an Accredited Training Program with an Integrated Rural Track to a Rural Nonhospital Site—If an urban hospital rotates residents in an accredited training program with an integrated rural track to a rural nonhospital site throughout all 3 years of training, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(g)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the integrated rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital and the rural nonhospital site.

(B) Beginning with the fourth year of the integrated rural track's existence, the rural track FTE limitation is equal to the product of:

(*1*) The highest number of residents in any program year who, during the third year of the integrated rural track's existence, are training in the integrated rural track at the urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site throughout all 3 years of training, and

(*2*) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(C) This would apply to accredited training programs with integrated rural tracks that were in existence prior to 1997.

The commenter explained that this language is designed to address the unique program at the commenter's hospital, and it also is date sensitive so that newer programs would be required to comply with the existing criteria in the existing regulations.

Response: We have concerns about the commenter's proposal. First, the commenter assumes a separate definition of ''integrated rural track,'' which, as explained above, we currently do not have. Even if we were to adopt such a change in policy, the cut-off date of 1997 in paragraph (C) of the commenter's proposed changes seems arbitrary; there is nothing in the statute that would serve as a basis to simply grandfather existing ''integrated rural track'' programs and not provide for new ones post-1997. Accordingly, we are not adopting such a change in our rural track policy as the one described by the commenter.

Comment: One commenter thought that if a hospital's rural track program has been in existence since 1993, then the 4th program year is 1997. The commenter explained that when the FTE cap went into effect, the hospital was capped at 15 FTEs. The hospital subsequently added another three residents at its own expense. The commenter stated that it interprets § 413.86(g)(11)(v)(A) to mean that the hospital would only be able to count the additional three FTE residents for the rural track count. The commenter urged us to reconsider this language as it relates to hospitals with only one residency program, because the commenter was unsure whether or not all the residents in the program count toward the rural track FTE count. The commenter believed that for hospitals with only one residency program that existed prior to 1996, all rural track residents included in the original hospital FTE cap should be counted toward the rural FTE count.

Response: The commenter correctly interprets the intent of the regulation at § 413.86(g)(11)(v)(A), which states that only those FTEs in the rural track that were not already counted as part of the

hospital's FTE cap may be considered when calculating the hospital's rural track FTE limitation and count. In the scenario the commenter outlined above, if the first program year of the rural track program began on July 1, 1993, then the fourth program year would begin on July 1, 1996, not in 1997. Because 15 FTEs were already included in the hospital's FTE cap, assuming the urban hospital qualifies to count the FTEs, only 3 out of the 18 FTE residents training in the program may be considered in determining the hospital's rural track FTE limitation and counts (the specific rural FTE limitation and count are dependent upon which scenario the hospital's program fits under § 413.86(g)(11)).

We do not believe it is necessary to revise this policy for hospitals whose only GME program is the rural track program that was in existence prior to 1996, as the commenter suggested. Hospitals that had rural track programs in existence in 1996 were able to count those residents training at the urban hospital at that time as part of their initial FTE caps. Our existing policy on rural tracks at § 413.86(g)(11) provides additional assistance to these hospitals by allowing them to count separately in their rural track FTE limitations, FTE residents not included in the FTE cap but participating in a rural track.

Accordingly, we are adopting the provisions in the August 1, 2000 interim final rule with comment period implementing section 407(c) of Public Law 106–113 as final.

In addition, we are making a technical correction. The regulations at § 413.86(g)(6) currently state, ''If a hospital established a new medical residency training program as defined in paragraph (g)(9) of this section * * *.'' When we revised the regulations at § 413.86(g)(9) to redesignate the paragraph as § 413.86(g)(12) in the August 1, interim final rule with comment period, we inadvertently did not make a corresponding revision at § 413.86(g)(6). Therefore, we are revising § 413.86(g)(6) to read ''If a hospital established a new medical residency training program as defined in paragraph (g)(12) of this section * * *'' We are making the same revision to the regulations for IME at § 412.105(f)(vii).

d. Not Counting Against Numerical Limitation Certain Residents Transferred from a Department of Veterans AffairsHospital's Residency Program That Loses Accreditation(Section 407(d) of Public Law 106–113 and new 42 CFR 412.105(f)(1)(xii) and 413.86(g)(10))

Section 407(d) of Public Law 106–113 addressed the situation where residents were training in a residency training program at a Veterans Affairs (VA) hospital and then were transferred on or after January 1, 1997, and before July 31, 1998, to a non-VA hospital because the program in which the residents were training would lose its accreditation by the ACGME if the residents continued to train at the VA hospital. In this situation, the non-VA hospital may receive a temporary adjustment to its FTE cap to reflect those residents who were transferred to the non-VA hospital for the duration that those transferred residents were training at the non-VA hospital. In the August 1, 2000 interim final rule with comment period, we specified that, in order to receive this adjustment, the non-VA hospital must submit a request to its fiscal intermediary for a temporary adjustment to its FTE cap, document that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specify the length of time the adjustment is needed.

We noted that section 407(d) of Public Law 106–113 only refers to programs that would lose their accreditation by the ACGME. This provision does not apply to accreditation by the American Osteopathy Association (AOA), the American Podiatry Association (APA), or the American Dental Association (ADA).

Under section 407(d)(3) of Public Law 106–113, this policy is effective as if included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

We added §§ 412.105(f)(1)(xii) and 413.86(g)(10) to incorporate the provisions of section 407(d) of Public Law 106–113.

We did not receive any comments on this provision and are adopting it as final.

e. Initial Residency Period for Child Neurology Residency Programs (Section 312 of Public Law 106–113 and 42 CFR 413.86(g)(1))

Generally, section 1886(h)(5)(F) of the Act defines the term ''initial residency period'' to mean the ''period of board eligibility.'' The period of board eligibility is defined in section 1886(h)(5)(G) of the Act as the period recognized by ACGME as specified in the *Graduate Medical Education Directory* which is published by the American Medical Association. The initial residency period limitation was designed to limit full Medicare payment for direct GME to the time required to train in a single specialty. Therefore, the initial residency period is determined based on the minimum time required for a resident to become board eligible in a specialty and the published periods included in the *Graduate Medical Education Directory.* During the initial residency period, the residents are weighted at 1.0 FTE for purposes of Medicare payment. Residents seeking additional specialty or subspecialty training are weighted at 0.5 FTE.

In order to become board eligible in child neurology, residents must complete training in more than one specialty. Thus, for example, before the effective date of section 312 of Public Law 106–113, if a resident enrolled in a child neurology residency program by first completing 2 years of training in pediatrics (which is associated with a 3-year initial residency period), followed by 3 years of training in child neurology, the resident would be limited by the initial residency period of pediatrics. Section 312 of Public Law 106–113 amended section 1886(h)(5) of the Act by adding at the end a clause (v) which states that ''in the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.'' (The initial residency period for pediatrics is currently 3 years). The policy under section 312(b) of Public Law 106–113 applies to future child neurology residents and to child neurology residents who have already begun their training (for whom an initial residency period was already established). However, it does not apply to residents who have completed their child neurology training before July 1, 2000.

In the August 1, 2000 interim final rule with comment period, we revised § 413.86(g)(1) to reflect that, effective on or after July 1, 2000, for residency programs that began before, on, or after

November 29, 1999, the period of board eligibility and the initial residency period for child neurology is now the period of board eligibility for pediatrics plus 2 years. We noted that the initial residency period is the same for all child neurology residents, regardless of whether or not the resident completes the first year of training in pediatrics or neurology.

We did not receive any comments on this provision and are adopting it as final.

f. Technical Amendment

In the August 1, 2000 interim final rule with comment period, we indicated that it had come to our attention that the first sentence of the then existing § 413.86(g)(1) contains a technical error. The first sentence of this paragraph reads ''For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year.'' This section of the regulation was revised as a result of section 13563(b) of Public Law 103–66, and was effective only until June 30, 1995. Generally, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Therefore, we revised the first sentence of paragraph (g)(1) of § 413.86 accordingly. The remainder of paragraph (g)(1) of § 413.86 was unchanged.

We did not receive any comments on this provision and are adopting it as final.

I. Additional Payment to Hospitals that Operate Approved Nursing and Allied Health Education Programs

Under sections 1861(v) and 1886(a) of the Act, hospitals that operate approved nursing or allied health education programs may be eligible for the reimbursement of their reasonable costs of operating such programs. Section 1886(h) of the Act establishes the methodology for determining payments to hospitals for the direct costs of GME programs. Section 1886(h) of the Act, as implemented in regulations at 42 CFR 413.86, specifies that Medicare payments for direct costs of GME are based on a prospectively determined per resident amount (PRA). The PRA is multiplied by the number of full-time equivalent residents working in all areas of the hospital complex (and nonhospital sites, where applicable), and the product is then multiplied by the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payment.

Section 1886(h)(3)(D) of the Act, as added by section 4624 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for direct costs of GME associated with services to Medicare+Choice (managed care) enrollees for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment for direct GME is calculated by (1) multiplying the aggregate approved amount (that is, the product of the PRA and the number of FTE residents working in all areas of the hospital (and nonhospital sites, if applicable)), by the ratio of the number of inpatient bed days that are attributable to Medicare+Choice enrollees to total inpatient bed days, and (2) multiplying the result by an applicable percentage.

The applicable percentages are 20 percent for portions of cost reporting periods occurring in calendar year 1998, 40 percent in calendar year 1999, 60 percent in calendar year 2000, 80 percent in calendar year 2001, and 100 percent in calendar year 2002 and subsequent years. (Section 1886(d)(11) of the Act, as added by section 4622 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for IME associated with services to Medicare+Choice enrollees for portions of cost reporting periods occurring on or after January 1, 1998, as well. However, the Medicare+Choice IME payments are irrelevant for the purposes of this section of the interim final rule with comment period, because although section 541 of Public Law 106–113 affects the payments for Medicare+Choice direct GME, it in no way affects the payments for Medicare+Choice IME.)

1. Provisions of the August 1, 2000 Interim Final Rule with Comment Period (Section 541 of Public Law 106–113 and 42 CFR 413.86(d) and 413.87)

Section 541 of Public Law 106–113 further amended section 1886 of the Act by adding subsection (l) and amending section 1886(h)(3)(D) to provide for additional payments to hospitals for nursing and allied health education programs associated with services to Medicare+Choice enrollees. Hospitals that operate approved nursing or allied health education programs, as defined under the regulations at 42 CFR 413.85, and receive Medicare reasonable cost reimbursement for these programs, would receive additional payments. This provision is effective for portions of cost reporting periods occurring in a calendar year, beginning with calendar year 2000.

Section 1886(l) of the Act, as added by section 541 of Public Law 106–113, specifies the methodology to be used to calculate these additional payments and places a limitation, that is, $60 million, on the total amount that is projected to be expended in any calendar year. We refer to the total amount of $60 million or less as the payment ''pool.'' We emphasize that we use the term ''pool'' solely for ease of reference; the term reflects an estimated dollar figure, a number that is plugged into a formula to calculate the amount of additional payments. The term ''pool'' does not refer to a discrete fund of money that is set aside in order to make the additional payments (thus, for example, if the estimated ''pool'' is $50 million, we use the number $50 million to calculate the amount of additional payments, but this does not mean that we set aside $50 million in a separate fund from which we make the additional payments). The total amount of additional payments is based on the ratio of estimated total direct GME payments for Medicare+Choice enrollees to estimated total Medicare direct GME payments, multiplied by the total Medicare nursing and allied health education payments. Under section 541 of Public Law 106–113, a hospital would receive its share of these additional payments in proportion to the amount of Medicare nursing and allied health education payments received in the cost reporting period that ended in the fiscal year that is 2 years prior to the current calendar year, to the total amount of nursing and allied health payments made to all hospitals in that cost reporting period. Section 541(b) of Public Law 106–113 amended section 1886(h)(3) of the Act to provide that direct GME payments for Medicare+Choice utilization will be reduced to account for the additional payments that are made for nursing and allied health education programs under the provisions of section 1886(l) of the Act.

In the August 1, 2000 interim final rule with comment period, we implemented section 541 by establishing regulations at 42 CFR 413.87 to incorporate the provisions of section 1886(l) of the Act. We specified the rules for a hospital's eligibility to receive the additional payment under section 1886(l), the requirements for determining the additional payment to each eligible hospital, and the methodologies for calculating each additional payment and for calculating the payment ''pool.'' The preamble language regarding § 413.87 can be found in the August 1, 2000 interim final rule with comment period (65 FR 47036 through 47039).

We also made a conforming change to §§ 413.86(d)(4) through (d)(6) to account

for the revised methodology in determining a hospital's Medicare+Choice direct GME payments.

2. Provisions of the June 13, 2001 Interim Final Rule with Comment Period

a. Additional Payment to Hospitals That Operate Approved Nursing and Allied Health Programs (Section 512 of Public Law 106–554 and 42 CFR 413.87)

Public Law 106–554 further amended section 1886(l)(2)(C) of the Act. Specifically, section 512 of Public Law 106–554 changed the formula for determining the additional amounts to be paid to hospitals for Medicare+Choice nursing and allied health costs. Under Public Law 106–113, as described above, the additional payment amount was determined based on the proportion of each individual hospital's nursing and allied health education payments to total nursing and allied health education payments made across all hospitals. This formula does not account for a hospital's specific Medicare+Choice utilization. Section 512 of Public Law 106–554 revised this payment formula to specifically account for each hospital's Medicare+Choice utilization. Accordingly, we made conforming changes at § 413.87 to reflect this change. The changes are effective for portions of cost reporting periods occurring on or after January 1, 2001. We refer the reader to the preamble of the June 13 interim final rule with comment period for a detailed description of the revised methodology for calculating the additional payments (66 FR 32178).

We revised § 413.87 to incorporate the provisions of section 512 of Public Law 106–554.

b. Technical Amendment

In the June 13, 2001 interim final rule with comment period, we indicated that it had come to our attention that the regulations at § 413.86(d)(4) and § 413.87(d) contained errors. The regulations at § 413.86(d)(4) had read, ''Effective for cost reporting periods beginning on or after January 1, 2000, the product derived from step three is reduced in accordance with the provisions of § 413.87(f).'' Consistent with the statutory effective date and to clarify the intent of the reference to § 413.87(f), we revised § 413.86(d)(4) to state that, ''Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year as described at § 413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.'' We also made a conforming change to § 413.87(d), which had read, ''Subject to the provisions of paragraph (f) of this section * * *.'' Instead, we revised this language to state, ''Subject to the provisions of § 413.86(d)(4) * * *.''

J. Payment for Bad Debts (Section 541 of Public Law 106–554 and 42 CFR 413.80)

Section 4451 of Public Law 105–33 required that allowable bad debt reimbursement for hospitals be reduced by 25 percent for cost reporting periods beginning during FY 1998, by 40 percent for cost reporting periods beginning during FY 1999, and by 45 percent for cost reporting periods beginning during a subsequent fiscal year.

In the June 13, 2001 interim final rule with comment period (66 FR 32183), we implemented section 541 of Public Law 106–554. Section 541 amended section 1861(v)(1)(T) of the Act, thereby modifying the reduction in payment for Medicare beneficiary bad debt for hospitals made by section 4451 of Public Law 105–33. Specifically, this provision reduced the amount of bad debts otherwise treated as allowable reductions in revenue, attributable to the deductibles and coinsurance amounts, by 30 percent for cost reporting periods beginning during FY 2001 and later. Therefore, for cost reporting periods beginning during the year 2001 and later, hospital bad debt amounts otherwise allowable will be reimbursed at 70 percent of the total allowable amount. In the June 13 interim final rule with comment period, we revised § 413.80 to implement this change.

We did not receive any comments on this provision and, therefore, are adopting the proposed revision to § 413.80 as final.

V. Changes to the Prospective Payment System for Capital-Related Costs

A. End of the Transition Period

Federal fiscal year (FY) 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs. For the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The 10-year transition period established to phase-in the prospective payment system for capital-related costs is effective for cost reporting periods beginning on or after October 1, 1991 (FY 1992) and before October 1, 2001 (FY 2002). Beginning in FY 2001, the last year of the 10-year transition period for the prospective payment system for hospital capital-related costs, capital prospective payment system payments are based solely on the Federal rate for the vast majority of hospitals. Since FY 2001 is the final year of the capital transition period, we will no longer determine a hospital-specific rate for FY 2002 in section III. of the Addendum of this final rule. For cost reporting periods beginning on or after October 1, 2001, payment for capital-related costs for all hospitals, except those defined as new hospitals under § 412.324(b), will be determined based solely on the capital standard Federal rate.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold-harmless payment methodology during the transition period.

During the transition period, a hospital paid under the hold-harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on

a portion of the Federal rate; or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions were met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990.

Hospitals that are defined as ''new'' for the purposes of capital payments during the transition period (see § 412.300(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324. During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable capital-related costs during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months), beginning at least 1 year after the hospital accepts its first patient, serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation and through the remainder of the transition period, the hospital will be paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the 10-year transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

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

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, under amendments to the Act enacted by section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate as specified in the regulations at § 412.374. For capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

In the August 30, 1991 final rule (56 FR 43409), we established a capital exceptions policy, which provided for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that during the transition period, a hospital may receive additional payment under the exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would have received under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital has been subject to the capital prospective payment transition rules. The minimum payment percentages throughout the transition period for regular capital exceptions payments by class of hospitals are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for ''regular'' exceptions payments expires at the end of the transition period, that is, for cost reporting periods beginning after September 30, 2001. Capital prospective payment system payments are no longer adjusted to reflect regular exceptions payments at § 412.348 after that date. Accordingly, for cost reporting periods beginning on or after October 1, 2001, all hospitals other than those defined as ''new'' under § 412.324(b) will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

B. Special Exceptions Process

In the August 30, 1991 final rule (56 FR 43409), we established a capital exceptions policy at § 412.348, which provided for *regular* exception payments during the transition period. In the September 1, 1994 final rule (59 FR 45385), we added the *special* exceptions process, describing it as ''* * * narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects.''

Under the special exceptions provisions at § 412.348(g), an additional payment may be made through the 10th year beyond the end of the capital

prospective payment system transition period for eligible hospitals that meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent, and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001, as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the 10-year transition to the fully Federal capital prospective payment system. Therefore, hospitals are eligible to receive special exceptions payments for the 10 years after the cost reporting year in which they complete their project. Generally, if a project is completed in the hospital cost reporting period ending September 29, 2002, exceptions payments would continue through September 29, 2012. In addition, we believe that, for projects completed after the deadline, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects. We note that the August 1, 2000 final rule (65 FR 47095) incorrectly stated that special exceptions payments could extend through September 30, 2011; the date should have been September 29, 2012.

For each cost reporting period, the amount of the special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system. This comparison is offset or reduced by (1) any amount by which the hospital's cumulative payments exceed its cumulative minimum payments under the regular exceptions process for all cost reporting periods during which the hospital has been subject to the capital prospective payment system; and (2) any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding 75 percent of its operating DSH payments) exceed its Medicare inpatient operating and capital costs (or its Medicare inpatient margin). During the capital prospective payment system transition period, the minimum payment level under the regular exceptions process varied by class of hospital as set forth in § 412.348(c) and described in section V.A. of this preamble. After the transition period and for the duration of the special exceptions provision, the minimum payment level is 70 percent as set forth in § 412.348(g)(6).

As we indicated in the July 30, 1999 final rule (64 FR 41526), we have little information about the number of hospitals that may qualify for special exceptions payments or the projected dollar amount of special exception payments, because no hospitals are currently being paid under the special exceptions process. Until FY 2002, the special exceptions provision pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. In accordance with § 412.348(g)(7), a qualifying hospital may receive additional payments for up to 10 years from the year in which it completes a project that meets the project need and project size requirements of the special exception provision in §§ 412.348(g)(2) through (g)(5). Because a qualifying project under the special exceptions provision at § 412.348(g) must be completed (put into use for patient care) by the end of the hospital's last cost reporting period beginning before the end of the transition period (September 30, 2001), a hospital may receive special exception payments for 10 years through September 30, 2012. For example, an eligible hospital that completes a qualifying project in October 1993 (FY 1994) will be eligible to receive special exception payments up through FY 2003 (September 30, 2003).

In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, in the May 4, 2001 proposed rule, we proposed to add a new § 412.348(g)(9) to require that hospitals eligible for special exception payments under § 412.348(g) submit documentation to the intermediary indicating the completion date of their project (the date the project was put in use for patient care) that meets the project need and project size requirements outlined in §§ 412.348(g)(2) through (g)(5). We proposed that, in order for an eligible hospital to receive special exception payments, this documentation would have to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed. For example, if a hospital completed a qualifying project in March 1995, it would be required to submit documentation to the intermediary by October 1, 2001. If a hospital with a 12-month cost reporting period beginning on July 1 completed a qualifying project in November 2001, it would be required to submit documentation to the intermediary no later than September 30, 2002, which is 3 months after the end of its 12-month cost reporting period that began on July 1, 2001.

We did not receive any comments on our proposed revision to § 412.348 to add paragraph (g)(9). Accordingly, we are adopting the proposed revision as final without change.

C. Exceptions Minimum Payment Level

Section 412.348(h) limits the estimated aggregate amount of exceptions payments under both the regular exceptions and special exceptions process to no more than 10 percent of the total estimated capital prospective payment system payments in a given fiscal year. Consistent with the requirements for regular exceptions at § 412.348(c), in the May 4, 2001 proposed rule, we proposed that if we estimate that special exception payments would exceed 10 percent of total capital prospective payment system payments for a given fiscal year, we will adjust the minimum payment level of 70 percent by one percentage point increments until the estimated payments are within the 10-percent limit. For example, we could set the minimum payment level at 69 percent to ensure that estimated aggregate special exceptions payments do not exceed 10 percent of estimated total capital prospective payment system payments. If the estimate of aggregate special exceptions payments were still projected to exceed 10 percent of total capital prospective payment system payments, we would continue reducing the minimum payment level by one percentage point increments until the requirements in § 412.348(h) were satisfied. We proposed to revise § 412.348(g)(6) accordingly to reflect this policy.

We received no comments on this proposed change. Thus, we are revising § 412.348(g)(6) accordingly.

D. Exceptions Adjustment Factor

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348

relative to total capital prospective payment system payments. In estimating the proportion of regular exceptions payments to total capital prospective payment system payments during the transition period, we used the model originally developed for determining budget neutrality (described in Appendix B of this final rule) to determine the exception adjustment factor, which was applied to both the Federal and hospital-specific rates. In the May 4, 2001 proposed rule, we described our proposed methodology for determining the special exceptions adjustment used in establishing the Federal capital rate as follows:

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exception payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

In order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exception payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and later. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of capital prospective payment system. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, for the proposed rule, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we proposed to estimate the project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2000.

PPS Year	Cost reports periods beginning in . . .
IX	FY 1992
X	FY 1993
XI	FY 1994
XII	FY 1995
XIII	FY 1996
XIV	FY 1997
XV	FY 1998
XVI	FY 1999

Because the project phase-in may overlap 2 cost reporting years, we proposed to add together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the project-size must meet the following requirements: (1) $200 million; or (2) 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We proposed to calculate the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We proposed not to subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we modeled the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 1999). For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data we proposed to ignore any regular exception payments that these hospitals may otherwise have received as if there had not been regular exceptions during the transition period. In projecting an eligible hospital's special exception payments, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital prospective payment system payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Because hospitals may receive regular exceptions payments up through the end of their last cost reporting period beginning before October 1, 2001, hospitals with cost reporting periods beginning on a day other than October 1 will continue to receive regular exception payments until the end of their FY 2002 cost reporting period. Therefore, these hospitals will only receive special exception payments for the remainder of Federal FY 2002. Consequently, the special exceptions payments made in FY 2002 will be less than for subsequent years since they are only being paid a special exception payment for a portion of FY 2002.

Based on more recent data and HCRIS cost reports updated through March 2001, our modeling of special exception payments produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals	Special exceptions as a fraction of capital payments to all hospitals weighted by portion of FY 2002 for which special exceptions are paid
PPS IX	.....	.....	.....
PPS X	.....	.....	.....
PPS XI	3	.....	.....
PPS XII	6	0.0001	0.0001
PPS XIII	7	0.0001	0.0000
PPS XIV	14	0.0002	0.0001
PPX XV	17	0.0009	0.0002
PPS XVI	23	0.0009	0.0007

Currently, the PPS XVI cost reports in HCRIS are incomplete because there is a 2-year lag time between the end of a hospital's cost reporting period and the submission and processing of the cost reports for HCRIS. In particular, we have not received all the cost reports for hospitals whose cost reporting periods begin in July. We expect that more hospitals may qualify for special exceptions once data from later HCRIS updates are available. In addition, hospitals still have two more cost reporting periods (PPS XVII and PPS XVIII) to complete their projects in order to be eligible for special exceptions.

In the May 4, 2001 proposed rule (66 FR 22705), we estimated that about 30 additional hospitals could qualify for special exceptions. Based on more recent data, we still estimate that about 30 additional hospitals could qualify for special exceptions. Thus, we project that special exception payments as a fraction of capital payments to all hospitals is approximately 0.0025. However, after weighting this amount to account for the FY 2002 phase-in of special exception payments, we project that this factor is approximately 0.0012. These projections have not changed since the publication of the May 4, 2001 proposed rule (66 FR 22706). We received no comments on our proposed methodology for determining the special exceptions adjustment used in establishing the capital Federal rate. Because special exceptions are budget neutral, we will offset the Federal capital rate by 0.12 percent for special exceptions for FY 2002. Therefore, the final special exceptions adjustment factor is equal to 0.9988 (1–0.0012) to account for special exception payments in FY 2002.

E. Provisions Relating to Capital Prospective Payments in the June 13, 2001 Interim Final Rule With Comment Period

In the June 13, 2001 interim final rule with comment period, we implemented section 301(b) of Public Law 106–554 (66 FR 32176). Section 301(b) provides for a special rule for payment for the operating standardized amounts for hospitals other than SCHs for FY 2001. For discharges occurring on or after April 1, 2001, and before October 1, 2001, the update to the operating standardized amounts for hospitals other than SCHs is equal to the market basket percentage increase plus 1.1 percentage points. This provision amends the prior statutory 1.1 percent reduction to the update to the FY 2001 operating standardized amounts for hospitals other than SCHs as provided by section 4401(a)(1) of Public Law 105–33 and 406 of Public Law 106–113.

Section 1886(d)(3)(B) of the Act directs the Secretary to adjust the inpatient operating national standardized amounts to account for the estimated proportion of operating DRG payments made to payments in outlier cases. Accordingly, as a result of this change to the update to the operating standardized amounts for discharges occurring on or after April 1, 2001 and before October 1, 2001, we revised the fixed-loss outlier threshold. The regulations at § 412.312(c) establish a unified outlier methodology for inpatient operating and inpatient capital-related costs, which utilizes a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital prospective payment system payments.

Because operating DRG payments increased as a result of implementing section 301 of Public Law 106–554, the fixed-loss outlier threshold decreased, which resulted in an increase in estimated outlier payments. Thus, the capital national outlier adjustment factor was revised. Since the revision to the fixed-loss outlier threshold also affected total capital payments, the exceptions adjustment factor was also revised in order to maintain budget neutrality. The exceptions adjustment factor is determined based on an estimate of the ratio of exception payments to total capital payments. The GAF/DRG budget neutrality factor was also revised. We discuss the impact of changes to the rates and payments under the capital prospective payment system that result from implementation of section 301 of Public Law 106–554 in further detail in the Addendum of this final rule.

We did not receive any comments on the revised FY 2001 capital Federal rate for discharges occurring on or after April 1, 2001 and before October 1, 2001 as a result of implementing section 301(b) of Public Law 106–554.

VI. Changes for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§§ 413.40(b)(4) and (g))

1. Updated Caps for Existing Hospitals and Units

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105–33) established caps on the target amounts for certain existing hospitals and units excluded from the prospective payment system for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The caps on the target amounts apply to the following three classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

In addition, section 4416 of Public Law 105–33 limited payments for

psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals that first received payments on or after October 1, 1997. Payment for these hospitals and units is limited to the lesser of the hospital's operating costs per case or 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated and adjusted for differences in area wage levels.

A discussion of how the caps on the target amounts and the payment limitation were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000), and the July 30, 1999 final rule (64 FR 41529). For purposes of calculating the caps for existing facilities, the statute required the Secretary to estimate the national 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996 without adjusting for differences in area wage levels. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year.

Section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to also provide for an appropriate wage adjustment to the caps on the target amounts for existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. On August 1, 2000, we published an interim final rule with comment period that implemented this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000 (65 FR 47026) and a final rule that implemented this provision for cost reporting periods beginning on or after October 1, 2000 (65 FR 47054). This final rule addresses the wage adjustment to the caps and payment limitations for cost reporting periods beginning on or after October 1, 2001 as proposed in the May 4, 2001 proposed rule.

For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106–113, requires the Secretary to also provide for existing hospitals ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

Consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment, we account for differences in wage-related costs by adjusting the caps to account for the following:

First, as stated in the May 4 proposed rule, we adjust each hospital's target amount to account for area differences in wage-related costs. For each class of hospitals (psychiatric, rehabilitation, and long-term care), we determine the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the labor-related portion of costs (or 0.71553). Similarly, we determine the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, as we stated in the May 4 proposed rule, we account for wage differences among hospitals within each class by dividing the labor-related portion of each hospital's target amount by the hospital's wage index under the hospital inpatient prospective payment system. Within each class, each hospital's wage-neutralized target amount was calculated by adding the wage-neutralized labor-related portion of its target amount and the nonlabor-related portion of its target amount. Then, the wage-neutralized target amounts for hospitals within each class were arrayed in order to determine the national 75th percentile caps on the target amounts for each class.

Taking into account the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (wage-neutralized using the FY 2000 acute care wage index), the wage adjustment provided for under Public Law 106–113, and the applicable update factor based on the market basket percentage increase for FY 2001, in the August 1, 2000 final rule (65 FR 47096), we established the FY 2001 caps on the target amounts as follows:

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric	$8,131	$3,233
Rehabilitation	15,164	6,029
Long Term Care	29,284	11,642

In reviewing our methodology for wage neutralizing the hospital specific target amounts, it appears that we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585 through 41593), which is based on wage data after taking into account geographic reclassification under section 1886(d)(8) of the Act. As stated in the May 4 proposed rule, we are revising the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data. We recalculate the limit for new excluded hospitals and units, as well as calculate the cap for existing excluded hospitals and units, using the pre-reclassification wage index. The pre-reclassification wage index is the same wage index used under the prospective payment system for skilled nursing facilities (SNFs) and was included in Table 7 of the July 30, 1999 SNF final rule (64 FR 41690). (We note that both SNFs and ambulatory surgical centers use the prospective payment system inpatient wage index without regard to the prospective payment system reclassification as a proxy for variations in local costs.)

As we stated in the August 1, 2000 final rule, long-term care hospitals, rehabilitation hospitals and units, and psychiatric hospitals and units that are exempt from the prospective payment system are not subject to the prospective payment system hospital reclassification system under section 1886(d)(10)(A) of the Act. This section establishes the MGCRB for the purpose of evaluating applications from short-term, acute care providers. There is no equivalent statutory mandate for HCFA to develop an alternative board for long-term care hospitals, psychiatric hospitals and units, and rehabilitation hospitals and units. In addition, while it would be feasible to allow units physically located in prospective payment system hospitals that have been reclassified by the MGCRB to use the wage index for the area to which that hospital has been reclassified, at the present time there is no process in place to make reclassification determinations for freestanding excluded providers. There are approximately 1,000 freestanding excluded providers. Therefore, in the interest of equity, we believe that, in determining a hospital's wage-adjusted

cap on its target amount, it is appropriate for excluded hospitals and units to use the wage index associated with the area in which they are physically located (MSA or rural area) and the prospective payment system reclassification under section 1886(d)(10) of the Act is not applicable. This policy is also consistent with the policy for SNFs and ambulatory surgical centers that use the acute care, inpatient hospital prospective payment system wage index and that does not allow for reclassifications since there is no analogous determinations process to the MGCRB. The MGCRB only has authority over the prospective payment system for acute care hospitals.

Therefore, based on the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment to the caps, we have determined the labor-related and nonlabor-related portions of the caps on the target amounts for FY 2002 using the methodology outlined above.

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric	$8,429	$3,351
Rehabilitation	$15,736	$6,256
Long-Term Care	$31,490	$12,519

These labor-related and nonlabor-related portions of the caps on the target amounts for FY 2002 are based on the current estimate of the market basket increase for excluded hospitals and units for FY 2002 of 3.3 percent and reflect the change in applying the pre-reclassified hospital inpatient prospective payment system wage index as discussed above. Furthermore, in accordance with section 307(a) of Public Law 106–554, which amended section 1886(b)(3) of the Act, the labor-related and nonlabor-related portions of the cap for long-term care hospitals for FY 2002 are increased by 2 percent. A further discussion of this provision as it appeared in the June 13, 2001 interim final rule with comment period (66 FR 32181) that will implement provisions of Public Law 106–554 for FY 2001 and for periods in FY 2001 from April 1, 2001 through September 30, 2001, appears in section VI.A.4. of this preamble.

Finally, to determine payments described in § 413.40(c), the cap on the hospital's target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2002, a hospital's applicable wage index is the pre-reclassified wage index under the hospital inpatient prospective payment system (see § 412.63). The wage index values are computed based on the same data used to compute the FY 2002 wage index values for the hospital inpatient prospective payment system without taking into account changes in geographic reclassification under the following: Section 1886(d)(8)(B) of the Act for certain rural hospitals; section 401 of Public Law 106–113; reclassifications based on MGCRB decisions; or the Secretary's decisions under sections 1886(d)(8) through (d)(10) of the Act. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the pre-reclassified wage index is in Tables 4G and 4H of this final rule. A hospital's applicable wage index corresponds to the area in which the hospital or unit is physically located (MSA or rural area).

2. New Excluded Hospitals and Units

a. Updated Caps (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case; or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments as adjusted for differences in area wage levels.

As discussed earlier, in reviewing our methodology for wage neutralizing the hospital-specific target amounts, it appears we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule, which is based on wage data after taking into account geographic reclassifications under section 1886(d)(8) of the Act. Therefore, as we proposed in the May 4 proposed rule, we also are revising the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data in our calculation of the limit for new excluded hospitals and units.

The amounts included in the following table reflect the updated and recalculated 110 percent of the wage neutralized national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2002. These figures are updated to reflect the projected market basket increase of 3.3 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to prospective payment system reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2002 labor-related share	FY 2002 nonlabor-related share
Psychiatric	$6,815	$2,709
Rehabilitation	$13,465	$5,353
Long-Term Care	$16,701	$6,640

b. Changes in Type of Hospital Classification (§§ 412.23 and 412.25)

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105–33) establishes caps on the target amounts for existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. Section 4416 of Public Law 105–33 amended section 1886(b)(7) of the Act to provide for a limitation on payment for new excluded psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Since the establishment of the caps on target amounts and the payment limitations, there has been an increase in the number of hospitals requesting a change from one classification type to another (for example, from rehabilitation to long-term care). Regulations at § 412.22(d) state that ''For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.''

Even though the existing regulations directly address only a hospital that changes from a prospective payment system hospital to an excluded hospital, our longstanding policy has been that a change of any classification type can be effective only at the beginning of the provider's cost reporting period. As we stated in the May 4 proposed rule, although the existing regulations do not directly address changes in a classification type of excluded hospital, we believe that a change from one classification type of excluded hospital to another type of excluded hospital is analogous to a change from a prospective payment system hospital to an excluded hospital. Therefore, based on our belief that it would be consistent with our longstanding policy, we proposed to amend our regulations to specify that a change from one excluded hospital classification type to another type is allowed only at the beginning of the hospital's cost reporting period.

The rationale underlying our present policy of requiring that these types of changes should only be effective at the beginning of the cost reporting period is the need to avoid any undue (and possibly significant) administrative burden that could result from doing otherwise (for example, cost allocation, cost reporting requirements, certification issues). If we were to accept changes in an excluded hospital's classification type from one type of classification to another, other than at the beginning of the cost reporting period, the hospital would need to file a terminating cost report with respect to its original classification as well as file a separate cost report for the remainder of the cost reporting period with respect to its new classification. Filing these cost reports would involve gathering the appropriate cost data, allocating the data, and apportioning the data between the two hospital classes. Additionally, we would have to validate the cost reports. To allow these types of changes in the middle of a cost reporting period would result in a significant administrative burden. We point out that this burden is applicable equally for either a change from a prospective payment system hospital to an excluded hospital, or a change from one excluded hospital classification type to another classification type. Therefore, as we proposed in the May 4 proposed rule, we are amending the regulations to provide that the effective date of any of these classification changes is only at the beginning of a provider's cost reporting period (§ 412.23(i), for excluded hospitals, and § 412.25(f), for excluded units).

We did not receive any public comments on our proposed revisions of §§ 412.23(i) and 412.25(f). Therefore, we are adopting the proposed revisions as final.

3. Effective Date of Exclusion of Long-Term Care Hospitals

Existing regulations at § 412.23(e) require a newly established long-term care hospital to operate for at least 6 months with an average length of stay in excess of 25 days in order to qualify for exclusion from the inpatient hospital prospective payment system as a long-term care hospital. Other regulations at § 412.22(d) allow changes in a hospital's status from not excluded to excluded to occur only at the start of a cost reporting period. These two regulations, taken together, typically require a hospital to operate for at least 6 months under the prospective payment system before becoming eligible for payment at the more favorable rate under section 1886(b)(3) of the Act.

These regulations were challenged in litigation by a chain organization that operates a large number of long-term care hospitals (*Transitional Hospitals Corporation of Louisiana, Inc.* v. *Shalala*, 222 F.3d 1019 (D.C. Cir. 2000) (*THC*)). Although the court of appeals in this case found that the Secretary has ample authority to adopt current regulatory provisions, it also concluded that the Secretary could have considered other policy options. Consequently, it remanded the case to the agency for the agency to consider whether it wanted to continue its existing policy or adopt a policy of either ''self-certification'' or ''retroactive adjustment.'' Generally, under a self-certification approach, hospitals that have not yet demonstrated the required average length of stay would be excluded from the prospective payment system based on a commitment to maintain such a length of stay. Under a retroactive adjustment approach, a hospital's long-term care classification would be made effective with the beginning of the 6-month period in which it demonstrated the required average length of stay. Payments for that period initially would be made under the prospective payment system and then adjusted retroactively to amounts payable for an excluded long-term care hospital once length of stay was successfully established.

As directed by the court of appeals, we reviewed the issues raised in this case in light of the court's decision, and specifically considered the options of self-certification and retroactive adjustment. Our proposals, and the alternatives we considered before arriving at them, are explained in detail in the May 4, 2001 proposed rule (66 FR 22708) and summarized below.

Although we understood that we have discretion to select other policy options, we proposed to continue our policy of requiring hospitals seeking long-term care hospital classification to demonstrate the required average length of stay based on 6 months of data, instead of permitting these hospitals to ''self-certify'' the required average length of stay.

We noted that the statute provides the agency with broad authority to determine the methodology by which facilities can qualify for exclusion as long-term care hospitals (section 1886(d)(1)(B)(iv)(I) of the Act specifies that ''a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days'' qualifies for exclusion as a long-term care hospital). As the court of appeals decided, the parenthetical phrase *as determined by the Secretary* ''gives the Secretary considerable leeway to determine whether to require prospective, contemporaneous, or retrospective evaluation and payment.'' (*THC* at 1026.)

Having proposed to continue our policy of not allowing a hospital to self-certify the required average length of stay in order to be paid as an excluded long-term care hospital, we also considered the effective date of excluded status for a hospital that has demonstrated the required average length of stay. We considered making long-term care classification effective retroactively with the beginning of the 6-month period in which the hospital demonstrated the required average length of stay. However, we believe that such retroactive application of excluded status is inappropriate.

Therefore, we proposed to continue our policy that a hospital's payment as a long-term care hospital would be effective with the beginning of the hospital's cost reporting period that follows the determination to classify the hospital as a long-term care hospital.

Comment: One commenter expressed general approval of the policies set forth in the May 4 proposed rule, stating that hospitals seeking long-term care status should be required to demonstrate the required length of stay based on 6 months of data.

Response: We appreciate the support of the commenter for our proposed policy.

Comment: Another commenter disagreed with our proposed policy and requested that we reconsider it. This commenter stated that our proposals were inconsistent with the purpose of

the prospective payment system exclusion, resulted in disparate treatment of similarly situated providers, and produced inappropriate reimbursement shortfalls. The commenter also argued that our reliance on the general prospective nature of the prospective payment system was misplaced and inconsistent with our regulations.

Response: We have examined the commenter's contentions in detail but have concluded that they do not warrant adoption of a policy different from the one we have proposed. First, we disagree that our proposal is inconsistent with the purpose of the long-term care hospital exclusion. We agree with the commenter that the purpose of the exclusion is to ensure adequate reimbursement to hospitals that treat long-stay patients. However, the question addressed by our proposed policy is how to determine which providers meet the criteria for being considered hospitals that treat such patients. We believe that our proposed policy is the most appropriate methodology for making this determination. We believe that our proposed policy furthers the purpose of the exclusion by ensuring that only hospitals that can demonstrate compliance with the statutorily required length of stay receive long-term care hospital status. It also ensures that decisions granting such status are implemented in accordance with the general goals of the prospective payment system and our longstanding policies regarding the effective dates of changes in the various components of providers' prospective payment system payment rates.

Second, we do not agree with the commenter's contention that our proposed policy results in disparate treatment of similarly situated providers because we allow rehabilitation hospitals to self-certify that they will meet certain aspects of the criteria for exclusion but do not allow long-term care hospitals to do so. We dealt with this issue at length in the May 4 proposed rule and explained there that the differences in the nature of the two types of facilities, and the differences in their statutory and regulatory definitions, justified their varying treatment for these purposes. The commenter's assertion that the self-certification option that is permitted as to rehabilitation facilities and the same type of option that is not permitted as to long-term care hospitals both relate to the types of patient to be admitted—even if true in some general sense—is not sufficient in our view to overcome the clear differences in the two types of facilities that informs our different treatment of them.

Similarly, the fact that long-term care hospitals must meet a series of regulatory conditions of participation does not make them sufficiently similar to rehabilitation hospitals so as to make the use of self-certification by long-term care hospitals appropriate, as the commenter suggested. All hospitals must meet conditions of participation to participate in the Medicare program. However, that does not change the fact that, as pointed out in the May 4 proposed rule, the statute itself requires that a hospital meet the length of stay criterion to qualify as a long-term care hospital, while the statute grants the Secretary broad authority to promulgate various criteria for a hospital to qualify as a rehabilitation hospital. It is the additional certainty supplied by the additional criteria for status as a rehabilitation hospital under this authority that has led us to allow rehabilitation hospitals to self-certify that they will comply with the remaining criterion. Such certainty is lacking in the case of long-term care hospitals, since the length-of-stay criterion is extremely difficult to predict into the future at any particular point in time.

Conditions of participation exist as a matter of Medicare survey and certification activities to ensure that the provider meets the requirements of participation in the program, not as definitional criteria that establish a hospital's status for payment purposes. As a result, they do not provide the type of additional certainty that derives from the nature and number of rehabilitation hospital criteria and that might warrant allowing long-term care facilities to self-certify that they will meet the required average length of stay. The commenter also pointed out that there are various criteria in § 412.22(e) that a facility must meet to qualify as a hospital within a hospital. However, the existence of these criteria does not alter the fact that a hospital must meet the statutory length-of-stay criterion in order to qualify as a long-term care hospital, making self-certification by such a hospital inappropriate.

The commenter suggested that, if we reject its suggestion to allow self-certification by long-term care hospitals, we should then adopt a policy whereby we would pay a long-term care hospital provisionally under the prospective payment system during its initial cost reporting period; evaluate compliance with the length-of-stay requirement at the end of that period; and, if the requirement had been met, retroactively adjust its reimbursement to provide for payment on a reasonable cost basis. We do not agree with the commenter that such a scheme would result in no significant administrative burden because the retroactive adjustments could be made as part of the cost report review process. Whether performed as part of this process or not, the scheme the commenter suggested would result in just the type of burden that has generally led to our making changes in components of the prospective payment system rates prospective only, as noted in the May 4 proposed rule. As also noted in the proposed rule, such prospective only changes are consistent with our approach, validated by the courts in cases like *THC, Methodist Hospital of Sacramento*, and *County of Los Angeles*, of balancing absolute accuracy and finality and favoring the latter in the context of the prospective payment system. We find nothing in the commenter's suggestions on this point that persuades us to depart from our intention to adopt our proposed policy.

Third, we disagree with the commenter's statement that our proposed policy produces inappropriate reimbursement shortfalls. To the contrary, as noted above, our policy is designed to identify those hospitals that qualify for appropriate payment as long-term care facilities, in accordance with principles of prospectivity that have been approved by the courts. Although the commenter stated that Congress did not intend for us to require that new long-term care hospitals wait at least 6 months before being excluded from the hospital inpatient prospective payment system, the court of appeals in *THC* specifically found that the Medicare statute did not preclude just such a policy. We also note that, while the policy described in the May 4 proposed rule is one of longstanding, Congress has never seen fit to amend the statute to require us to implement long-term care exclusions immediately upon a new hospital's participation in the program.

Finally, we do not agree with the commenter that our reliance on the prospective nature of the prospective payment system in arriving at our proposed policy is misplaced or that the policy conflicts with our regulations. As to the former point, as noted above, we believe that the court decisions in *THC, Methodist Hospital of Sacramento*, and *County of Los Angeles* directly support the adoption of our proposed policy. We do not find the commenter's analyses of these cases persuasive. They cannot be distinguished on the basis that they apply to hospitals paid under the hospital inpatient prospective payment system but not to hospitals excluded

from the prospective payment system, as the commenter suggested. Making the determination whether a hospital is excluded from or subject to the hospital inpatient prospective payment is an important part of implementing the prospective payment system payment methodology, and, like other aspects of that implementation, should be guided by the general principles underlying the prospective payment system. That is especially so since the ''default'' payment mode for acute care hospitals is payment subject to the hospital inpatient prospective payment system, and reasonable cost payment does not result until it is determined (again, as part of administering the prospective payment system) that the hospital's status should change to excluded status.

Moreover, while the court of appeals in *Methodist Hospital* may have stated that retroactive corrections are not necessarily inconsistent with the hospital inpatient prospective payment system, all three cases stand for the proposition that neither is the agency's prospective only policy inconsistent with the statute. Indeed, that is largely the point of the court of appeals' decision in *THC*—that the agency has broad statutory authority to adopt retroactive, contemporaneous, or prospective application of decisions granting long-term care status. For the reasons set out in the May 4 proposed rule and in this final rule, we have elected the latter policy. The policy at issue here is thus quite different from the one at issue in *Georgetown University Hospital* v. *Bowen*, 862 F.2d 323 (D.C. Cir.1988), which the commenter also cited, because the court of appeals held that that policy was contrary to express Congressional intent.

Nor is our proposed policy contrary to our regulations. The only regulations that the commenter cited in support of this point are those that implement the statutory requirement that a hospital cost report be subject to retroactive adjustment upon review by the intermediary after the close of the applicable cost reporting period. However, those regulations, and the statutory provisions they implement, merely establish a year end ''book-balancing'' process to reconcile the amount of estimated payments made to the provider during the year with the actual amount of reimbursement the provider is due for that year, determined in accordance with the methods prescribed by the agency. Among those methods is prospective only application of the prospective payment system status decisions. These regulations then are in no way inconsistent with our proposed policy.

4. Payment for Long-Term Care Hospital Costs: Provisions of the June 13, 2001 Interim Final Rule with Comment Period (Section 307 of Public Law 106–554 and 42 CFR 413.40(c)(4))

a. Increase in the Limitation on the Target Amounts for Long-Term Care Hospitals

As stated in the June 13 interim final rule with comment period (66 FR 32181), in the August 29, 1997 final rule with comment period (62 FR 46018), in accordance with section 4414 of Public Law 105–33, we implemented section 1886(b)(3)(H) of the Act, which provides for caps on the target amounts for existing and new excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on the target amounts apply to three classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. In establishing the caps on the payment amounts within each class of hospital for *new* hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, instructed the Secretary to provide an appropriate adjustment to take into account area differences in average wage-related costs. However, because the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to adjust for area differences in wage-related costs in establishing the caps on the target amounts within each class of hospital for *existing* hospitals, we did not adjust for wage-related differences for existing facilities. In the August 1, 2000 interim final rule with comment period (65 FR 47039), we implemented section 121 of Public Law 106–113, which further amended section 1886(b)(3)(H) of the Act by directing the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for *all* psychiatric hospitals and units, rehabilitation hospitals and units and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Section 1886(b)(3)(H)(iii) of the Act, as added by section 121 of Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

The August 1, 2000 final rule (65 FR 47096) listed the FY 2001 labor-related share and nonlabor-related share of the national 75th percentile wage-neutralized cap for long-term care hospitals as follows:

- Labor-related Share: $29,284
- Nonlabor-related Share: $11,642

The final rule also discussed that within each class a hospital's wage-adjusted cap on its target amount is determined by adding the hospital's nonlabor-related portion of the national wage-neutralized cap to its wage-adjusted labor-related portion of the national wage-neutralized cap. A hospital's wage-adjusted labor-related portion is calculated by multiplying the labor-related portion of the national wage-neutralized 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system as shown in Tables 4A and 4B of the August 1, 2000 final rule (65 FR 47149 through 47156) corresponding to the area in which the hospital is physically located (MSA or rural area).

Section 307(a) of Public Law 106–554 further amended section 1886(b)(3) of the Act and provides for a 2-percent increase to the wage-adjusted 75th percentile cap on the target amount for long-term care hospitals effective for cost reporting periods beginning during FY 2001. This provision is only applicable to long-term care hospitals that were subject to the cap for existing excluded providers as specified in § 413.40(c).

In accordance with section 1886(b)(3) of the Act as amended, for cost reporting periods beginning during FY 2001, in the June 13 interim final rule with comment period, we specified the following revised labor-related and nonlabor-related shares of the cap on the target amount for long-term care hospitals, which reflect the 2-percent increase:

REVISED FY 2001 NATIONAL CAP FOR LONG-TERM CARE HOSPITALS

FY 2001 labor-related share	FY 2001 nonlabor-related share
$29,870	$11,875

Note that the national 75th percentile wage-neutralized caps on the target amount for the other excluded hospitals and units subject to the caps under section 1886(b)(3)(H) of the Act (psychiatric and rehabilitation) are not affected by section 307 of Public Law 106–554. In the June 13 interim final rule with comment period, we revised the regulations at § 413.40(c)(4)(iii) to incorporate this change.

We did not receive any public comments on our proposed revision of § 413.40(c)(4)(iii) to incorporate this provision of the statute and, therefore, are adopting it as final.

b. Increase in the Target Amounts for Long-Term Care Hospitals

As stated in the June 13, 2001 interim final rule with comment period (66 FR 32181), in the August 29, 1997 final rule with comment period (62 FR 46016) we implemented the amendment to section 1886(b)(3)(B) of the Act, as made by section 4411 of Public Law 105–33, which set forth the applicable rate-of-increase percentage for cost reporting periods beginning during FY 1999 through FY 2002. The rate-of-increase is equal to the market basket increase percentage minus an amount based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recent available cost reporting period. The applicable rate-of-increase percentages (update factors) for FY 2001 are described in the August 1, 2000 final rule (65 FR 47125). For FY 2001, the market basket increase percentage was forecast at 3.4 percent, which results in an update for long-term care hospitals for FY 2001 of between 0.9 percent and 3.4 percent, or 0 percent, depending on the hospital's costs in relation to its rate-of-increase limit.

In addition to the increase to the cap on the target amounts for long-term care hospitals, section 307(a) of Public Law 106–554 also amended section 1886(b)(3) of the Act to provide for a 25-percent increase to the target amounts determined under section 1886(b)(3)(A) of the Act for long-term care hospitals, for cost reporting periods beginning in FY 2001, subject to the applicable cap on the target amounts. Thus, this provision required a revision to the determination of each long-term care hospital's FY 2001 target amount as specified in § 413.40(c)(4). As stated in the June 13 interim final rule with comment period, for cost reporting periods beginning during FY 2001, the hospital-specific target amount otherwise determined for a long-term care hospital as specified in the regulations at § 413.40(c)(4)(ii) is multiplied by 1.25 (that is, increased by 25 percent), subject to the limitation that the revised FY 2001 target amounts for a long-term care hospital cannot exceed its wage-adjusted national cap as required by section 1886(b)(3) of the Act, as amended by section 307(a) of Public law 106–554. We noted that the 25-percent increase to the target amount under section 307(a) of Public Law 106–554 is applicable only to long-term care hospitals, and not to other excluded hospitals as defined in section 1886(d)(1)(B) of the Act (psychiatric and rehabilitation hospitals and units, children's and cancer hospitals).

In the June 13, 2001 interim final rule with comment period, we revised the regulations at § 413.40(c)(4)(iii) to incorporate this change.

We did not receive any public comments on this revision of § 413.40(c)(4)(iii) to incorporate this provision of the statute and, therefore, are adopting it as final.

5. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

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

Shortly, we will be issuing a final rule on the establishment of the prospective payment system for inpatient rehabilitation facilities, to be effective January 1, 2002.

6. Increase in the Incentive Payment for Excluded Psychiatric Hospitals and Units: Provision of the June 13, 2001 Interim Final Rule with Comment Period (Section 306 of Public Law 106–554 and 42 CFR 413.40(d)(2))

As we stated in the June 13 interim final rule with comment period (66 FR 32181), for cost reporting periods beginning before October 1, 1997, a hospital that had inpatient operating costs less than, or equal to, its ceiling was paid its costs plus the lower of 50 percent of the difference between inpatient operating costs and the ceiling or 5 percent of the ceiling. Section 4415 of Public Law 105–33 amended section 1886(b)(1)(A) of the Act to provide that for cost reporting periods beginning on or after October 1, 1997, if a hospital's net inpatient operating costs are less than or equal to, the ceiling, the amount of the bonus payment would be the lower of 15 percent of the difference between the inpatient operating costs and the ceiling or 2 percent of the ceiling. Section 306 of the Public Law 106–554 further amended section 1886(b)(1)(A) of the Act, as it applied to a psychiatric hospital or unit, to provide that effective for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if a psychiatric hospital or unit's net inpatient operating costs are less than, or equal to, the ceiling, the amount of the bonus payment is the lower of 15 percent of the difference between the inpatient operating costs and the ceiling, or 3 percent of the ceiling.

In the June 13 interim final rule with comment period, we revised the regulations at § 413.40(d)(2) to incorporate this change.

We did not receive any public comments on our revision to § 413.40(d)(2) in the interim final rule with comment period to incorporate this provision of the statute and, therefore, are adopting it as final.

7. Changes in the Types of Patients Served or Inpatient Care Services That Distort the Comparability of a Cost Reporting Period to the Base Year are Grounds for Requesting an Adjustment Payment in Accordance with Section 1886(b)(4) of the Act

Section 4419(b) of Public Law 104–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period occurs over a 2-year

period or longer. An excluded hospital or unit must first file its cost report for the previous fiscal year with its intermediary within 5 months after the close of the previous fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in a final rule on adjustments granted for cost reports ending in the previous Federal fiscal year, since those adjustments have not even been requested by that time. However, in an attempt to provide interested parties at least some relevant data on adjustments, we are publishing data on requests for adjustments that were processed by the fiscal intermediaries or CMS during the previous Federal fiscal year.

The table below includes the most recent data available from the intermediaries and CMS on adjustment payments that were adjudicated during FY 2000. By definition, these were for cost reporting periods ending in years prior to FY 1999. The total adjustment payments awarded to excluded hospitals and units during FY 2000 are $12,344,419. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payment
Psychiatric	40	$19,172,613	$9,114,944
Rehabilitation	8	6,128,515	2,254,393
Long-Term Care	3	827,821	814,971
Children's	1	160,111	160,111

B. Critical Access Hospitals (CAHs)

Section 4201 of Public Law 105–33 amended section 1820 of the Act to create a nationwide Medicare Rural Hospital Flexibility (MRHF) Program to replace the 7-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program. Under section 1820(c)(2) of the Act, as amended, a State could designate certain rural hospitals as CAHs if they were located a specified distance from other hospitals, made 24-hour emergency care available, and kept inpatients for a limited period of time. Additionally, CAH staffing requirements differed from those of other hospitals under Medicare and CAHs received payment for inpatient and outpatient services on the basis of reasonable cost. A comprehensive discussion of CAHs within the context of the MRHF Program may be found in the August 29, 1997 **Federal Register** (62 FR 45970 and 46008–46010).

1. Permitting Certain Facilities to be Designated as CAHs (Section 401(b) of Public Law 106–113 and 42 CFR 485.610)

As discussed in the August 1, 2000 interim final rule with comment period, one of the threshold criteria for designation as a CAH under section 1820(c)(2)(B)(i) of the Act is that the hospital must be rural as defined in section 1886(d)(2)(D)(ii) of the Act. Section IV.A. of the interim final rule with comment period discussed the option of urban to rural classification for a ''subsection (d)'' hospital authorized by section 401(a) of Public Law 106–113 under an amendment to section 1886(d)(8) of the Act. Section 401(b)(2) of Public Law 106–113 amended section 1820(c)(2)(B) of the Act to authorize a State to designate a hospital in an urban area as a CAH if, under one of the criteria set forth in section 1886(d)(8)(E) of the Act, it would be treated as being located in the rural area of the State in which the hospital is located. Section 401(b)(2) only provides authority for a hospital to meet the rural requirement. We note that the hospital would have to otherwise meet the statutory and regulatory requirements governing CAH designation.

The first criteria in section 401(a) specified that a hospital will be treated as located in a rural area if the hospital is located in a rural census tract of an MSA, as determined under the most recent Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992. In Appendix B of the August 1, 2000 interim final rule with comment period, we published a listing of existing hospitals that may qualify as CAHs because they are located in Goldsmith areas.

In the August 1, 2000 interim final rule, we specified that the application procedures and effective dates for an urban hospital seeking to reclassify as rural in order to apply for CAH status under section 1820(c)(2)(B)(i) of the Act were set forth in new § 412.103 that implements section 401(a), and discussed in section IV.C. of that interim final rule with comment period (65 FR 47041). In the August 1 interim final rule with comment period, we revised the regulations on location for CAHs at § 485.610(b) to reflect this amendment.

We did not receive any comments on the revised section of the regulations in the interim final rule with comment period and have not made any further changes to it.

2. Exclusion of CAHs From Payment Window Requirements

Section 1886 of the Act specifies the requirements governing payment to full-service hospitals for the operating costs of inpatient hospital services under both the inpatient hospital prospective payment system and the limits on the target amounts for hospitals excluded from the prospective payment system. ''Operating costs of inpatient hospital services'' are defined in section 1886(a)(3) of the Act, which provides in part that costs of certain services provided to a beneficiary during the 3 days (or in the case of an excluded hospital or unit, during the 1 day) immediately preceding the patient's admission are to be included in the payments for costs under the inpatient hospital prospective payment system, or costs subject to the target amount for excluded hospitals and units. This part of the definition is sometimes referred to as the ''payment window'' requirement. Regulations implementing the payment window requirement are found at § 412.2(c)(5) for hospitals subject to the prospective payment system, and § 413.40(c)(2) for hospitals excluded from the prospective payment system.

As we stated in the May 4, 2001 proposed rule, payment to CAHs for inpatient services is not made under the

inpatient hospital prospective payment system mandated by section 1886 of the Act, nor are CAHs considered to be hospitals excluded from the inpatient hospital prospective payment system. Instead, payment is made on a reasonable cost basis, as mandated by section 1814(l) of the Act. Neither section 1814(l) nor section 1861(v) of the Act (which defines ''reasonable cost'') requires application of the payment window to services furnished on an outpatient basis immediately before admission to a CAH. Therefore, we stated in the May 4 proposed rule that we have determined that the payment window provision does not apply to CAHs. To clarify this point and avoid possible misapplication of the payment window, we proposed to amend § 413.70(a)(l) to provide that the requirements of §§ 412.2(c)(5) and 413.40(c)(2) do not apply to CAHs.

Comment: Several commenters expressed support for the proposal to explicitly exclude CAHs from the payment window requirements. None of the commenters opposed the proposal or suggested changes to it.

Response: We appreciate the commenters' support and are adopting the proposed regulation amendments as final.

3. Availability of CRNA Pass-Through for CAHs

Generally, anesthesia services furnished to a hospital patient by a certified registered nurse anesthetist (CRNA) must be billed to the Part B carrier and payment is made under the applicable fee schedule provisions of § 414.60. However, certain rural hospitals that furnish no more than 500 surgical procedures requiring anesthesia per year and meet other specified requirements are exempted from the fee schedule. These hospitals are paid on a reasonable cost basis for their costs of anesthesia services furnished by qualified nonphysician anesthetists. The exemption is provided in accordance with section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) (as added by section 608(c)(2) of the Family Support Act of 1988 (Public Law 100–185), as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239)). We have codified this exemption at § 412.113(c).

We pointed out in the May 4 proposed rule that, although § 412.113(c) does not specifically extend eligibility for the pass-through payment for CRNAs to CAHs, some CAHs have pointed out that they are similar to the rural hospitals that are eligible for this payment, in that they also furnish low volumes of surgical procedures requiring anesthesia and could face the same problem of potentially inadequate payment for CRNA services if they are not allowed to qualify for the pass-through payment. We share this concern.

We recognize that the legislation cited above, which provides the legal basis for the pass-through payments, refers only to ''hospitals,'' not to CAHs. Moreover, section 1861(e) of the Act states that ''the term ''hospital'' does not include, unless the context otherwise requires, a critical access hospital * * *.'' It is clear from section 1861(e) of the Act that CAHs are not to be considered hospitals under the Medicare law for most purposes. However, the reference to ''context'' in the provision indicates that CAHs may be classified as hospitals where, in specific contexts, it would be consistent with the purpose of the legislation to do so.

We stated that we believe this is the case with the statutory provisions authorizing pass-through payments for CRNA costs. The purpose of the pass-through legislation is to provide small rural hospitals with low surgical volumes with relief from the difficulties they might otherwise have in furnishing CRNA services for their patients. CAHs are by definition limited-service facilities located in rural areas and, as such, they serve a population much like those served by hospitals eligible for the pass-through payments. In some cases, an institution that now participates as a CAH may even have been eligible for the pass-through payments when it participated as a hospital. Such an institution would clearly be disadvantaged if it were to lose this status. Thus, in accordance with section 1861(e) of the Act and in light of the context of the pass-through legislation cited above, we consider CAHs to be ''hospitals'' for purposes of extending eligibility for the CRNA pass-through payments to them.

Therefore, in the May 4 proposed rule, we proposed to add a new § 413.70(a)(3) and revise §§ 413.70(a)(2), (b)(1), and (b)(6) to permit CAHs that meet the criteria for the pass-through payments in § 412.113(c) to qualify for pass-through payments for the costs of anesthesia services for both inpatient and outpatient surgeries, on the same basis as full service rural hospitals. As an unrelated technical correction, we proposed to revise § 413.70(b)(2)(i)(C) to delete the incorrect reference to § 413.130(j)(2) and replace it with a reference to reduction in capital costs under § 413.130(j). We also proposed to revise § 412.113(c) by changing the term ''hospital'' to ''hospital or CAH''.

Comment: Several commenters favored extension of the CRNA pass-through to CAHs. However, some commenters suggested that the pass-through be made available to all CAHs, even if they furnish 500 or more surgical procedures requiring anesthesia service in the prior year.

Response: Section 412.113(c), which is based on the provisions of the Medicare law, is specific with respect to the volume of surgeries that may be performed by facilities qualifying for the CRNA pass-through. The volume of surgeries is a criterion for a hospital to qualify for CRNA pass-through. As we are treating CAHs as hospitals for purposes of the CRNA pass-through, a CAH would have to meet the same qualifying criteria as would a hospital. Accordingly, we are not adopting the commenters' suggestion that the 500 procedure criterion be revised for CAHs.

Comment: One commenter stated that anesthesia services in many rural facilities are furnished by anesthesiologists rather than CRNAs, and suggested that pass-through also be made available for the costs of anesthesia services provided by anesthesiologists.

Response: The Medicare law is specific to CRNAs and does not offer similar treatment for costs of services of anesthesiologists. Therefore, we are not adopting this suggestion.

4. Payment to CAHs for Emergency Room On-Call Physicians (§ 413.70(b)(4))

Under section 1834(g) of the Act, Medicare payment to a CAH for facility services to Medicare outpatients is the reasonable costs of the CAH in providing such services. The term ''reasonable cost'' is defined in section 1861(v) of the Act and in regulations at 42 CFR Part 413, including, with specific reference to CAHs, § 413.70. Consistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15–1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary). However, under existing policy, the reasonable cost of CAH services to outpatients may not include any costs of compensating physicians who are not present in the facility but are on call.

Section 204 of Public Law 106–554 further amended section 1834(g) of the Act (as amended by section 201 of Public Law 106–554) by adding a new

paragraph (5). New section 1834(g)(5) of the Act provides that, in determining the reasonable costs of outpatient CAH services under sections 1834(g)(1) and 1834(g)(2)(A) of the Act, the Secretary shall recognize as allowable costs amounts (as defined by the Secretary) for reasonable compensation and related costs for emergency room physicians who are on call (as defined by the Secretary) but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility. The provisions of section 204 of Public Law 106–554 are effective for cost reporting periods beginning on or after October 1, 2001.

As we provided in the May 4 proposed rule, to implement the provisions of section 1834(g)(5) of the Act, we proposed to add a new paragraph (4) to § 413.70(b). The proposed § 413.70(b)(4) would permit the reasonable costs of CAH outpatient services to include the reasonable compensation and related costs of emergency room on-call physicians under the terms and conditions specified in the statute. As directed in the statute, under § 413.70(b)(4)(ii)(A) of the proposed rule, we defined ''amounts for reasonable compensation and related costs'' as those allowable costs of compensating emergency room physicians for being on call, to the extent these costs are found to be reasonable under the rules in § 413.70(b)(2).

In addition, as specified under § 413.70(b)(4)(ii)(A) of the proposed rule, we defined an ''emergency room physician who is on call'' as a doctor of medicine or osteopathy with training or experience in emergency care who is immediately available by telephone or radio contact, and who is available on site within the timeframes specified in our existing regulations under § 485.618(d). Existing § 485.618(d) specifies that the physician must be available on site (1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in item (2); or (2) within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

- The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act.
- The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.
- The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

We also believe that it is essential that physicians who are paid to be in on-call status in fact come to the facility when summoned. Therefore, we proposed to specify that costs of on-call emergency room physicians are allowable only if the costs are incurred under written contracts that require them to come to the CAH when their presence is medically required.

Comment: One commenter noted that existing regulations at § 413.70(a)(2) prohibit application, in making reasonable cost determinations for CAHs, of the reasonable compensation equivalent (RCE) limits on physician services to providers. The commenter expressed concern that more explicit reasonableness guidelines may be needed to ensure that costs recognized for on-call services are reasonable.

Response: We understand the commenter's concern, but note that existing reasonable cost rules at § 413.9(c)(2) authorize intermediaries to disallow costs of services that are ''substantially out of line'' with costs of other, similar providers in the same area. We will continue to monitor these costs and will consider proposing further or more specific reasonableness standards if necessary.

Comment: One commenter stated that contracts for emergency services are typically executed between a CAH and a physician group, and, for legal purposes, the individual physician is not distinguishable from the group. The commenter further stated that if the regulations prohibit the ''physician'' from otherwise furnishing services or being on call at another facility, the proposed language of the regulation may inadvertently prohibit any member of the physicians group from otherwise furnishing services or being on call.

Response: We have reconsidered the proposed language of § 413.70(b)(4) in the light of this comment, but find no basis for interpreting the proposed revised language in the way the commenter has suggested may occur. The proposed revised language makes it clear that it is the individual physician who is on call for the CAH that may not be otherwise engaged in furnishing physician's services, or on call at another provider or facility.

We are adopting proposed § 413.70(b)(4) as final.

5. Treatment of Ambulance Services Furnished by Certain CAHs (§ 413.70(b)(5))

Under section 1861(s)(7) of the Act, Medicare Part B covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated. Various Congressional reports indicate that Congress intended that (1) the ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and (2) only ambulance services to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered. (H.R. Rept. No. 89–213, 89th Cong., 1st Sess. at 37 (1995) and S. Rept. No. 89–404, 89th Cong., 1st Sess., Pt. I, at 43 (1995).

The Medicare program currently pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. (The term ''provider'' includes all Medicare-participating institutional providers that submit claims for Medicare ambulance services (hospitals, CAHs, SNFs, and home health agencies).) The term ''supplier'' means an entity that is independent of any provider. The reasonable charge methodology that is the basis of payment for ambulance services is determined by the lowest of the customary, prevailing, actual, or inflation indexed charge.

Section 4531(a)(1) of Public Law 105–33 amended section 1861(v)(1) of the Act and imposed an additional per trip limitation on reasonable cost payment to hospitals and CAHs for ambulance service. As amended, the statute provides that, in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor. This trip limit provision was first effective for services furnished during Federal fiscal year 1998 (October 1, 1997 through September 30, 1998).

Section 205 of Public Law 106–554 amended section 1834(l) of the Act by adding a new paragraph (8) to that section. New section 1834(l)(8) provides that the Secretary is to pay the reasonable costs incurred in furnishing ambulance services if such services are

furnished by a CAH (as defined in section 1861(mm)(1) of the Act), or by an entity owned and operated by the CAH. This provision in effect eliminates any trip limit that CAHs had been subject to as a result of section 1861(v)(1) of the Act, as amended by Public Law 105–33. However, section 205 further states that in order to receive reasonable cost reimbursement for the furnishing of ambulance services, the CAH or entity must be the only provider or supplier of ambulance services located within a 35-mile drive of the CAH. Section 205 is effective for services furnished on or after December 21, 2000, the date of enactment of Public Law 106–554.

As stated in the May 4 proposed rule, to implement the provisions of section 1834(l)(8) of the Act, we proposed to add a new paragraph (5) to § 413.70(b) to permit a CAH, or an entity owned or operated by a CAH, to be paid for furnishing ambulance services on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services within a 35-mile drive of the CAH. In determining whether there is any other provider or supplier of ambulance services within a 35-mile drive of a CAH or entity, we first identify the site where the nearest other ambulance provider or supplier garages its vehicles, and then determine whether that site is within 35 miles, calculated as the shortest distance in miles measured over improved roads. An improved road for this purpose is be defined as any road that is maintained by a local, State, or Federal government entity, and is available for use by the general public. Consistent with the change, in the May 4 proposed rule concerning § 412.92(c)(1) relating to SCH determinations (as explained in section IV.A. of this preamble), we proposed to consider improved roads to include the paved surface up to the front entrance of the hospital and, for purposes of § 413.70(b)(5), the front entrance of the garage.

Comment: Several commenters recommended that we support a legislative change that would eliminate the 35-mile requirement and allow all designated CAHs owning ambulance services to be reimbursed at cost. Another commenter requested that we support a legislative change to address situations where the distance requirement involves mountainous terrain or only secondary roads and that in such cases the mileage requirement be 15 miles.

Response: As the commenters pointed out, the statute as currently worded is clear as to applicability of the 35-mile rule in connection with the requirements for cost reimbursement of ambulance services furnished by CAHs. Therefore, we are not making any changes in the final regulation based on these comments.

Comment: One commenter described a situation where both the CAH and ambulance services are wholly owned by a city but the CAH provides operating services to the ambulance company. The commenter asked whether in such a case the ambulance services could be considered to be furnished by an entity that is wholly owned and operated by the CAH.

Response: As stated in section 205 of the Public Law 106–554, payment on a reasonable cost basis may be made for ambulance services furnished by a CAH, or an entity owned and operated by the CAH. The legislation does not allow us to extend similar treatment to ambulance services that may be operated but not owned by a CAH. Accordingly, we are not making any changes in this final rule based on this comment.

We are adopting proposed § 413.70(b)(5) as final without change.

6. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluation in CAHs

Section 1820 of the Act sets forth the conditions for designating certain hospitals as CAHs. Implementing regulations for section 1820 of the Act are located in 42 CFR part 485, Subpart F. Included in the conditions of participation regulations for CAHs in subpart F is the condition for surgical services (§ 485.639). Existing § 485.639 specifies that preanesthesia and postanesthesia services in a CAH can only be performed by a doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine. This Medicare condition of participation requirement regarding preanesthesia and postanesthesia evaluations for CAHs differs from, and is more restrictive than, the current requirement for acute care hospitals in general. In an acute care hospital, the CRNA is listed among the practitioners who may perform the preanesthesia and postanesthesia evaluations.

Our principal consideration in regulating providers is to ensure patient safety and high quality patient outcomes. As circumstances and health care environments change, we reassess regulations and propose changes accordingly.

In the May 4 proposed rule, we stated that when the regulations for the initial Rural Primary Care Hospital (RPCH) program (which later became the CAH program) were adopted, RPCHs were limited to patient stays of no more than 72 hours and to bed counts of no more than 6 acute care beds. We initially viewed RPCHs as very limited-service facilities that would be unlikely to perform any surgery beyond what might be done in a physician's office; therefore, we did not have a condition of participation for surgery. Section 102(a)(1) of the Social Security Amendments of 1994, Public Law 103–432, specifically authorized surgical care in RPCHs. In June 1995, we proposed a surgical condition of participation that incorporated the ambulatory surgery center (ASC) standards. We expected that the types of procedures done in a RPCH would most likely be those that could be done in ASCs. At the time, we received no comments in response to the proposed standards and therefore adopted them in the final RPCH conditions of participation that were published on September 1, 1995 (60 FR 45851).

In 1997, the RPCH (now CAH) program was expanded through a statutory change to include all States and to allow for an increase in bed size and length of stay (August 29, 1997 final rule, 62 FR 46035). Since that time, the program's original conditions of participation have been revised (and more recently have been proposed to be revised) to remove possible barriers to access to care. One example of our latest effort is our proposed rule to eliminate the Federal requirement for physician supervision of CRNAs in CAHs as well as in acute care hospitals and ASCs that was published in the **Federal Register** on January 18, 2001 (66 FR 96570).

Recently, provider and medical groups have suggested that CAHs may be at risk of losing the ability to provide access to appropriate surgical services without the full support of available CRNAs. They indicated that the existing regulations place the responsibility of the preanesthesia and postanesthesia evaluations on the operating practitioner, thereby creating a higher standard for CAHs than for other hospitals.

In an effort to eliminate or minimize potential access issues in rural areas and to recognize the CAH's program expansion, in the May 4, 2001 proposed rule, we proposed to revise § 485.639(b) to allow CRNAs to perform preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the proposed change would not permit CRNAs to practice beyond his or her licensed scope of practice or

the approved policies and procedures of the CAH.

We received 26 comments on our proposal.

Comment: Almost all of the 26 commenters supported our proposed change to the existing CAH conditions of participation to remove the requirement that only physicians can perform the preanesthesia and postanesthesia evaluations. The proposed regulation includes CRNAs among the practitioners that may perform these services. The commenters stated that the existing anesthesia evaluation requirements for CAHs are more restrictive than the requirements for hospitals and they impose an unnecessary burden on operating surgeons and the facilities.

Response: We appreciate the commenters' support.

Comment: One commenter stated that the proposed amendment to the condition of participation for surgical services under § 485.639(b) is ill-advised and should not be adopted, or, at the very least, should be postponed until the regulation regarding physician supervision of CRNAs in hospitals is finalized.

Response: The commenter correctly notes that we have not finalized the regulation to amend the physician supervision requirement for CRNAs (66 FR 96570, January 18, 2001). Our proposal that CRNAs perform preanesthesia and postanesthesia evaluations in CAHs in our May 4, 2001 proposed rule does not conflict with the January 18, 2001 proposed physician supervision regulation because our proposal does not affect current requirements for CRNAs, such as physician supervision. We mentioned the proposed physician supervision regulation in the preamble to the May 4 proposed rule as an example of our continual effort to review and evaluate our policies and regulations to better facilitate patient access and improve patient outcomes.

Comment: One commenter stated that there is no basis for us to assume that the safety-oriented anesthesia standards for CAHs should be any less stringent than those applicable to ambulatory surgical centers (ASCs).

Response: We acknowledge the commenter's concern regarding the anesthesia risk and evaluation standard for ASCs. Our existing conditions for coverage for ASCs require examination of patients by a physician immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. The ASC conditions for coverage also require evaluation of patients by a physician for proper anesthesia recovery prior to discharge from the ASC. We expect to review and modify the ASC condition of coverage, including the current anesthesia risk and evaluation standard, through a notice of proposed rulemaking in 2002. At that time, we will consider the commenter's concern.

Comment: One commenter stated that according to a recent national survey of one-third of rural hospital chief executives, almost 80 percent of the respondents reported that their institutions perform high-complexity surgery, such as gall bladder and stomach surgery. The commenter further stated that the hospital conditions of participation require that the preoperative evaluation be conducted by an individual qualified to administer anesthesia, but in the cases of a nurse anesthetist, the anesthesia provider must work under the supervision of the operating practitioner or an anesthesiologist. As such, the commenter summarized that the hospital requirements are not less stringent than the CAH requirements.

Response: The commenter has misunderstood the proposal to mean that physician supervision for CRNAs is eliminated. The proposed regulation, as noted in response to a previous comment, will not remove physician supervision of CRNAs.

Unlike in acute care hospitals, CRNAs are currently listed among the qualified practitioners who can administer anesthesia under physician supervision in CAHs but they cannot perform the preanesthesia and postanesthesia evaluations. In response to the provider industry's concerns with access to care, our proposal was that CRNAs be allowed to perform preanesthesia and postanesthesia evaluations.

We are adopting the proposed § 485.639(b) as final without change.

7. Clarification of Location Requirements for CAHs (§§ 485.610(b) and (c))

Under section 1820(c)(2)(B)(i) of the Act, a facility seeking designation by the State as a CAH must meet two distinct types of location requirements. First, the facility must either be actually located in a county or equivalent unit of local government in a rural area, as defined in section 1886(d)(2)(D) of the Act, or it must be located in an urban area as defined in section 1886(d)(2)(D) of the Act, but be treated as being located in a rural area under section 1886(d)(8)(E) of the Act. Second, the facility must also be located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or similar facility described in section 1820(c) of the Act, or it must be certified by the State as being a necessary provider of health care services to residents in the area. Implementing regulations for these provisions were published in an interim final rule with comment period in the **Federal Register** on August 1, 2000 (65 FR 47026) and are set forth at § 485.610(b).

As we indicated in the May 4 proposed rule, recently, concern has been expressed that § 485.610(b) does not accurately reflect the fact that a facility may satisfy the ''rural location'' requirement either by actually being located in a rural area or by being located in an urban area but qualifying for treatment as rural under section 1886(d)(8)(E) of the Act. In addition, we have received questions as to whether a potential CAH must meet both the rural location requirement and the requirement for location relative to other facilities (or certification by the State as a ''necessary provider'').

To avoid any further confusion, and ensure that our regulations reflect the provisions of the law accurately, we proposed to revise § 485.610(b) to clarify that a potential CAH must either be actually located in a rural area, or be treated as being rural under section 1886(d)(8)(E) of the Act. In addition, we proposed to place the provisions of the existing § 485.610(b)(5) in a newly created paragraph (c) entitled, ''Location relative to other facilities or necessary provider certification''. We proposed to relocate this provision in order to clarify that these criteria are separate from the rural location criteria. These changes do not reflect any change in policy; they are merely an attempt to improve the clarity of the regulations.

We did not receive any comments on these proposed changes and, therefore, are adopting them as final.

8. Other Legislative Changes Affecting CAHs

a. 96-hour Average Length of Stay Standard (Section 403(a) of Public Law 106–113 and 42 CFR 485.620(b))

As stated in the August 1, 2000 interim final rule with comment period, prior to the enactment of Public Law 106–113, section 1820(c)(2)(B)(iii) of the Act limited CAH designation only to facilities that provided inpatient care to each patient for a period of time not to exceed 96 hours, unless a longer period was required because of inclement weather or other emergency conditions, or a peer review organization (PRO) or equivalent entity, on request, waived the 96-hour restriction. Section 403(a) of

Public Law 106–113 amended section 1820(c)(2)(B)(iii) of the Act to require that the 96-hour limit on stays be applied on an annual average basis, and to delete the provisions regarding waiver of longer stays. Therefore, CAHs will be permitted to keep some individual patients more than 96 hours without a waiver request, so long as the facility's average length of acute stays in any 12-month cost reporting period is not more than 96 hours.

The effective date of this provision is November 29, 1999.

In the August 1, 2000 interim final rule with comment period, we revised the regulations on conditions of participation for length of stay for CAHs at § 485.620(b) to reflect this change.

Comment: One commenter noted that 96-hour length of stay limitation for CAHs clearly contemplates that the facility-wide average length of stay be computed as an hourly average, while Medicare cost report instructions require inpatient utilization to be reported by days of care rather than hours. The commenter expressed concern that if cost report data on days of care are converted to an hourly equivalent, this might overstate the length of stay for some facilities, since patients in the facility for only a few hours might be counted as having been inpatients for a full 24 hours. The commenter requested that we provide further directions to the fiscal intermediaries on the exact data to be used and the precise method to capture the length of stay average.

Response: We understand the commenter's concern and will ensure that any directions to intermediaries and State agencies on determining facility-wide average length of stay provide for calculating that average accurately. However, no change is needed to the proposed regulation and we are adopting it as final.

b. For-Profit Facilities (Section 403(b) of Public Law 106–113 and 42 CFR 485.610(a))

As stated in the August 1, 2000 interim final rule with comment period, prior to enactment of Public Law 106–113, section 1820(c)(2)(B) of the Act allowed only nonprofit or public hospitals to be designated as CAHs. Section 403(b) of Public Law 106–113 revises section 1820(c)(2)(B) of the Act to remove the words ''nonprofit or public'' before ''hospitals'', thus enabling for-profit hospitals to qualify for CAH status.

In that interim final rule with comment period, we revised the regulations on the conditions of participation related to the status and location for CAHs at § 485.610(a) to reflect this change.

We did not receive any comments on this provision and are adopting the revision to § 485.610(a) as final.

c. Closed and Downsized Hospitals (Section 403(c) of Public Law 106–113 and 42 CFR 485.610(a)(1))

Under section 1820(c)(2) of the Act, CAH designation was available only to facilities currently operating as hospitals. As stated in the August 1, 2000 interim final rule with comment period, section 403(c) of Public Law 106–113 amended the statute to permit a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of Public Law 106–113), if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act for CAH designation as of the effective date of its designation. The amendment also allows CAH designation for facilities that previously had been hospitals, but are currently State-licensed health clinics or health centers if they meet the revised criteria for designation under section 1820(c)(2) of the Act as of the effective date of designation. In the August 1 interim final rule with comment period, we revised the CAH criteria for State certification under regulations at § 485.610(a)(1) to reflect this change.

Although we received no public comment on the revision to § 485.610(a)(1), we have determined that one technical revision to § 486.610 is needed. We are making a technical correction to paragraph (a)(2) of § 485.610. Currently, that paragraph states that a closed facility may qualify for designation as a CAH only if it meets applicable criteria for designation under Subpart F of Part 485 ''as of November 29, 1999.'' However, under section 1820(c)(2)(C)(ii) of the Act, as added by section 403(c)(2) of Public Law 106–113, the facility must meet all other applicable requirements for CAH designation by the State as of the effective date of its designation as a CAH. Therefore, we are revising § 485.610(a)(2) to state that a closed facility may qualify for designation as a CAH only if it meets applicable criteria for designation under Subpart F of Part 485 as of the effective date of that designation.

In the August 1, 2000 final rule (65 FR 47052), we revised § 485.610 to reflect the provisions of section 403(c) of Public Law 106–113. However, we inadvertently did not make a conforming change to § 485.612, which continues to state that the applicant facility must be a hospital with a provider agreement to participate in the Medicare program at the time it applies for designation as a CAH. To correct this oversight and reflect the provisions of section 403(c) in the regulations at § 485.612, in the June 13, 2001 interim final rule with comment period (66 FR 32183), we revised § 485.612 to state that the requirement to have a provider agreement as a hospital at the time of application does not apply to recently closed facilities as described in § 485.610(a)(2) or to health clinics or health centers as described in § 485.610(a)(3).

We did not receive any comments on this provision and are adopting the provisions as final without change.

d. Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH (§§ 410.152 and 413.70))

As we indicated in both the August 1, 2000 and June 13, 2001 interim final rules with comment period, under the law in effect before the enactment of Public Law 106–113, clinical diagnostic laboratory services furnished by a CAH to its outpatients were, like other outpatient CAH services, paid for on a reasonable cost basis, subject to the Part B deductible and coinsurance provisions. With respect to coinsurance, this meant that the beneficiary was responsible for payment of 20 percent of the CAH's customary charges for the services and the CAH received payment from the Medicare program equal to 80 percent of its reasonable costs of furnishing the services.

In the August 1, 2000 interim final rule with comment period (65 FR 47042), we implemented section 403(e) of Public Law 106–113, which amended section 1833(a) of the Act and eliminated the Part B coinsurance and deductible for laboratory tests furnished by a CAH on an outpatient basis. Thus, CAHs were not permitted to impose a deductible or coinsurance charge on the beneficiary for these services. Also, in accordance with section 1833(a)(1)(D) and (a)(2)(D), as also amended by section 403(e) of Public Law 106–113, Medicare Part B was to pay 100 percent of the least of the amount determined under the local laboratory fee schedule, the national limitation amount for that test, or the amount of the charges billed for the tests.

The effect of this change was that clinical diagnostic laboratory tests furnished by a CAH to its outpatients, were paid for on the same basis as clinical diagnostic laboratory tests furnished by full-service hospitals to outpatients. Section 403(e)(2) of Public

Law 106–113 provided that this provision was effective with respect to services furnished on or after November 29, 1999. In the August 1, 2000 interim final rule with comment period, we clarified our policy and incorporated the provisions of section 403(e) of Public Law 106–113 in §§ 410.152 and 413.70 of the regulations.

As we indicated in the June 13, 2001 interim final rule with comment period (66 FR 32172), section 201(a) of Public Law 106–554 amended section 1834(g) of the Act to provide that there will be no collection of coinsurance, deductible, copayments, or any other type of cost sharing from Medicare beneficiaries with respect to outpatient clinical diagnostic laboratory services in a CAH.

Section 201(a) further provided that payment for these services will be made on a reasonable cost basis. Section 201(b) of the Public Law 106–554 amended section 1833(a) of the Act by eliminating any reference to CAHs receiving payment for outpatient clinical diagnostic laboratory services on a fee schedule basis. These amendments are effective for services furnished on or after November 29, 1999.

In the June 13 interim final rule with comment period, we incorporated the provisions of section 201 of Public Law 106–554 in § 413.70 of the regulations and changed the references cited in § 410.152(k)(2). To prevent any misunderstanding of the scope of section 201(a), we further revised § 413.70(b)(3)(iii) to clarify that payment to a CAH for clinical diagnostic laboratory tests for individuals who are not inpatients of the CAH will be made on a reasonable cost basis only if the individuals are outpatients of the CAH at the time the specimens are collected. Outpatient status will be determined under the definition in § 410.2, which provides that an ''outpatient'' is a person who has not been admitted as an inpatient but is registered as an outpatient and receives services (rather than supplies alone) from the CAH.

We indicated that we recognize that CAHs may appropriately function as reference laboratories, by performing clinical diagnostic laboratory tests on specimens from persons who do not meet the ''outpatient'' definition but have the specimens drawn at other locations, such as physician offices. Payment for clinical diagnostic laboratory tests for these other individuals (that are persons who are not patients of the CAH when the specimens are collected) will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

Comment: One commenter on the August 1, 2000 interim final rule expressed the view that it was Congress' intent to pay CAHs for clinical diagnostic laboratory tests for outpatients on the basis of reasonable costs, not on the basis of a laboratory fee schedule. The commenter suggested that we develop and implement regulations permitting reasonable cost payment for these laboratory services.

Response: As explained earlier, section 201(a) of Public Law 106–554 subsequently modified the Medicare law to clearly require reasonable cost payment for those services and we have implemented that provision in the June 13, 2001 interim final rule with comment period (which is being finalized in this final rule).

Comment: Some commenters stated that CAHs frequently perform clinical diagnostic laboratory tests on specimens drawn from patients at physician offices, nursing homes, and assisted living facilities in the community where the CAH is located, and in other rural communities. The commenters recommended that reasonable cost payment be made to the CAH for these services because, in the commenters' view, doing so would help support the provision of health care in these settings.

Response: As explained above and in the preamble to the June 13 interim final rule with comment period, section 201(a) of Public Law 106–554 mandates reasonable cost payment to CAHs for clinical diagnostic laboratory tests to CAH patients but does not provide similar payment when the CAH functions as a reference laboratory for patients who do not come to the CAH but are seen at other locations. The statute does not provide for such payment for services to non-CAH patients. We believe these laboratory services provided to individuals who are not patients of a CAH should be paid for on the same basis as such services are generally paid for regardless of the fact that the CAH reference laboratory performed the testing, and that payment for them on a reasonable cost basis would extend the CAH payment methodology far beyond the CAH itself. Thus, we are not adopting the commenters' recommendation.

Comment: One commenter suggested that we not require CAHs to refund coinsurance amounts collected from beneficiaries and third-party payers for clinical diagnostic laboratory tests furnished to outpatients on or after November 29, 1999. The commenter stated that this would be appropriate because there has been confusion among some CAHs as to their responsibilities in this area, and returning these amounts could be burdensome for the CAHs.

Response: Public Law 106–554 clearly and consistently states that, effective November 29, 1999, these services are not subject to deductible or coinsurance amounts. Medicare Intermediary Manual Transmittal No. 1799 and Medicare Hospital Manual Transmittal No. 757, issued in June 2000, reemphasized this point. Therefore, we are not making any change in this final rule based on this comment.

e. Assistance With Fee Schedule Payment for Professional Services Under All-Inclusive Rate

Prior to enactment of Public Law 106–113, section 1834(g) of the Act provided that the amount of payment for outpatient CAH services would be the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the physician fee schedule in accordance with the provisions of section 1848 of the Act.

In the August 1, 2000 final rule (65 FR 47100), we implemented section 403(d) of Public Law 106–113, which amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under an optional method. CAHs making this election would be paid amounts equal to the sum of the following costs, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance amounts):

- For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and
- For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included as outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this optional method are to be determined without regard to the amount of the customary or other charge. The amendment made by

section 403(d) was effective for cost reporting periods beginning on or after October 1, 2000.

In the June 13, 2001 interim final rule with comment period (66 FR 32172), we implemented section 202 of Public Law 106–554, which amended section 1834(g) of the Act to provide that when a CAH elects the option to be paid for Medicare outpatient services under the reasonable costs for facility services plus fee schedule amounts for professional services method, Medicare will pay 115 percent of the amount it would otherwise pay for the professional services. This provision is effective for items and services furnished on or after July 1, 2001.

In the June 13 interim final rule with comment period, we revised the regulations at § 413.70(b)(3) to reflect the change in the level of payment for professional services under the alternative payment method for outpatient CAH services.

Comment: One commenter asked for an explanation of the relationship between payment to CAHs for CRNA services to outpatients at 115 percent of the amounts that would otherwise be payable under the physician fee schedule, and the pass-through of CRNA services costs under § 412.113(c) as described in the proposed rule published on May 4, 2001 (66 FR 22646).

Response: Under the proposed changes to §§ 413.70 and 412.113(c) that we included in our May 4, 2001 proposed rule, a CAH would be able to qualify for the CRNA pass-through (that is, reasonable costs payment for its costs of compensating CRNAs for their professional services to inpatients and outpatients) on the same basis as a hospital. If a particular CAH qualified for the CRNA pass-through and chose to claim payment under that method for its CRNA compensation costs, it would be paid on a reasonable cost basis for those costs. However, neither the CAH nor the individual CRNAs would then be permitted to bill under the physician fee schedule for any CRNA services to CAH patients. In particular, if the CAH chose the elective (115 percent) method of payment for professional services to CAH outpatients, its billings for those services could not include any amounts for CRNA services.

If a CAH was not qualified for the CRNA pass-through (because, for example, it furnished 500 or more surgical procedures requiring anesthesia per year), or was qualified but chose not to claim payment under the pass-through method, but did choose payment for professional services to CAH outpatients under the elective (115 percent) method, payment for CRNA services to outpatients would be made under the elective (115 percent) method. Under these circumstances, the CAH could not claim any CRNA compensation costs for the services on its cost report.

Comment: One commenter asked whether payment under the optional method described in § 413.70(b)(3) is available for all professional services to CAH outpatients in CAH space, including professional services the commenter described as ''clinic visits''.

Response: The optional method applies to professional services otherwise included within outpatient CAH services provided to CAH outpatients. Outpatient CAH services are those medical and other services furnished by a CAH on an outpatient basis. Services that are not otherwise provided in a CAH on an outpatient basis, such as services provided by a home health agency owned or operated by a CAH, are paid under the payment rules applicable to the specific provider or supplier type and cannot be made under the optional method of payment for outpatient CAH services.

Comment: One commenter asked whether physicians and other practitioners who would otherwise be permitted to bill the Medicare Part B carrier for their professional services provided to CAH patients could reassign their Part B billing rights for those services to the CAH under the existing reassignment rules.

Response: The commenter is correct in understanding that practitioners may reassign their billing rights for professional services provided to CAH patients under applicable reassignment rules. Such reassignment would be needed to help ensure that there is not duplicate billing for those services.

Comment: One commenter stated that our current manual instructions require all professional services to the outpatients of a particular CAH to be billed under either the method in § 413.70(b)(2) (reasonable costs for facility services, with billing by the practitioner to the carrier for professional services) or the optional method in § 413.70(b)(3) (reasonable costs for facility services with billing by the CAH for professional services). The commenter asked whether a CAH would be permitted to elect the § 413.70(b)(3) method on a practitioner-by-practitioner basis, so that some practitioners' services would be billed by the CAH while others would be billed by the practitioner.

Response: We appreciate the commenter's request and note that we have already addressed this issue in our regulations. Specifically, the regulations at § 413.70(b)(3)(i) state that once a CAH elects the optional method for payment of outpatient CAH services for a cost reporting period, the optional payment method remains in effect for all of that period and applies to all outpatient CAH services furnished to outpatients of the CAH during that period.

Comment: Some commenters noted that section 202 of Pubic Law 106–554 makes the 115 percent payment option for professional services to CAH outpatients available for services furnished on or after July 1, 2001. However, the commenters also stated that our program instructions state that the systems changes needed to permit payment at that level will not be available before October 1, 2001. The commenters asked for confirmation that the payment at the 115 percent level for services furnished on or afterJuly 1, 2001, will be made available to CAHs electing payment under the optional method, and suggested various alternatives, including possible retroactive payment adjustments by the intermediary, by which this could be accomplished.

Response: We appreciate the commenters' suggestions. We will continue to explore all feasible approaches to ensuring that payment is made in accordance with statutory requirements and will consider the various suggestions made by the commenter as we work to achieve this result.

f. Conforming Change—Conditions of Participation Relating to Compliance With Hospital Requirements at Time of Application for CAH Designation (§ 485.612)

Under the law in effect prior to enactment of Public Law 106–113, CAH status was available to facilities only if they were hospitals at the time of their application for designation as CAHs. This requirement was implemented through regulations at § 485.610 (Condition of participation: Status and limitations) and § 485.612 (Condition of Participation: Compliance with hospital requirements at time of application). As we previously noted, section 403(c) of Public Law 106–113 added subparagraphs (C) and (D) to section 1820(c)(2) of the Act to specify that recently closed facilities and facilities that had downsized from hospital status to being a clinic or health center would also be eligible to apply for CAH designation.

As noted earlier, in the August 1, 2000 final rule(65 FR 47052), we revised our regulations at § 485.610 to reflect the provisions of section 403(c) of the

Public Law 106–113. However, we inadvertently did not make a conforming change to § 485.612, which continues to state that the applicant facility must be a hospital with a provider agreement to participate in the Medicare program at the time it applies for designation as a CAH. To correct this oversight and reflect the provisions of section 403(c) in the regulations at § 485.612, in the June 13, 2001 interim final rule with comment period(66 FR 32183), we revised § 485.612 to state that the requirement to have a provider agreement as a hospital at the time of application does not apply to recently closed facilities as described in § 485.610(a)(2) or to health clinics or health centers as described in § 485.610(a)(3).

We did not receive any comments on this regulation revision and are adopting it as final.

g. Participation in Swing-Bed Program (Section 403(f) of Public Law 106–113)

Section 403(f) of Public Law 106–113, entitled ''Improvements in the Critical Access Hospital Program,'' included a provision on swing-bed agreements. In the August 1, 2000 interim final rule with comment period, we indicated that since our existing regulations at § 485.645 already provide for swing beds in CAHs, we were not making any changes to our regulations based on this provision.

We did not receive any comments on this provison and are adopting our interim decision not to make any changes to our regulations as final.

C. Hospital Swing Bed Program

In the August 1, 2000 interim final rule with comment period (65 FR 47042), we indicated that section 408(a) of Public Law 106–113 amended section 1883(b) of the Act to remove the provision that in order for a hospital to enter into an agreement to provide Medicare post-hospital extended care services, the hospital had to be granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located. Section 408(b) of Public Law 106–113 amended section 1883(d) of the Act to remove the provisions under paragraphs (d)(2) and (d)(3) that placed restrictions on lengths of stays in hospitals with more than 49 beds for post-hospital extended care services. These provisions are effective on the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Act for payment for covered skilled nursing facility (SNF) services under the Medicare program; that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date.

The Medicare regulations that implemented the provision of section 1883(b) of the Act are located at § 482.66(a)(3). The regulations that implemented the provisions of sections 1883(d)(2) and (d)(3) of the Act are located at §§ 482.66(a)(6) and (a)(7). As a result of the changes made by section 408(a) and (b) of Public Law 106–113, in the August 1, 2000 interim final rule with comment period, we removed §§ 482.66(a)(3), (a)(6), and (a)(7). (Existing paragraphs (a)(4) and (a)(5) were redesignated as (a)(3) and (a)(4), respectively, as a result of the removal of existing paragraph (a)(3).)

We did not receive any comments on our revisions to the regulations in the interim final rule with comment period and are adopting them as final.

VII. MedPAC Recommendations

On March 1, 2001, the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the inpatient operating payment system. Those related to the inpatient prospective payment systems included: accounting for new technology in hospital prospective payment systems, implementation of an occupational-mix adjusted wage index for FY 2005, financial performance and inpatient payment issues, and elimination of the weighting factors for direct GME for specialties with training beyond the initial residency period. In the May 4, 2001 proposed rule, we responded to these recommendations (66 FR 22713–22714).

In addition, we addressed Recommendation 5A concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the prospective payment system in Appendix D to the proposed rule (and in Appendix C of this final rule).

A. Accounting for New Technology in Hospital Prospective Payment Systems (Recommendations 3D and 3E)

Recommendation 3D: For the inpatient payment system, the Secretary should develop formalized procedures for expeditiously assigning codes, updating relative weights, and investigating the need for patient classification changes to recognize the costs of new and substantially improved technologies.

Response: Section 533 of Public Law 106–554 directs the Secretary to develop a mechanism for ensuring adequate payment under the hospital inpatient prospective payment system for new medical services and technologies, and to report to Congress on ways to more expeditiously incorporate new services and technologies into that system. The discussion relating to new medical services and technologies was included in section II.D. of the May 4, 2001 proposed rule.

MedPAC states that a more formal system for assigning codes and investigating the need for DRG changes would have enabled the current system to more adequately respond to new technology. Although we believe the current process for assigning new codes has the advantage of being well-understood, we proposed a new process in the May 4 proposed rule. We will be finalizing this process in a separate final rule.

Recommendation 3E: Additional payments in the inpatient payment system should be limited to new or substantially improved technologies that add significantly to the cost of care in a diagnosis related group and should be made on a budget-neutral basis.

Response: Section 533 of Public Law 106–554 directed the Secretary to establish a mechanism by October 1, 2001. We will be finalizing this process in a separate final rule.

B. Occupational-Mix Adjusted Wage Index for FY 2005 (Recommendation 4)

Recommendation: To implement an occupation-mix adjusted wage index in FY 2005, the Secretary should collect data on wage rates by occupation in the fiscal year 2002 Medicare cost reports. Hospital-specific wage rates for each occupation should be supplemented by data on the mix of occupations for each provider type. The Secretary also should continue to improve the accuracy of the wage index by investigating differences in wages across areas for each type of provider and in the substitution of one occupation for another.

Response: In the May 4 proposed rule, we proposed to collect occupational mix data from hospitals through a supplemental survey to the cost report for cost reporting periods beginning during FY 2001. A more complete discussion of the proposed methodology in the May 4 proposed rule (66 FR 22674) and the public comments we received and our responses can be found in section III.C.3. of this final rule.

C. Financial Performance and Inpatient Payment Issues (Recommendations 5B, 5C, and 5D)

Recommendation 5B: In collecting sample patient-level data, CMS should seek to balance the goals of minimizing payment errors and furthering understanding of the effects of coding on case-mix change.

Response: The sample data referred to by MedPAC is the Payment Error Prevention Program (PEPP) Surveillance Sample. These data are collected to monitor the payment error rate for Medicare inpatient prospective payment system services and provide outcome data to measure PROs' performance in reducing payment errors in their respective States. This information can be appropriately weighted to reflect the true distribution of DRGs nationally. The sample data supplant the DRG validation sample that MedPAC used in its original 1996 through 1998 estimates. The current PEPP Surveillance Sample doubles the size of the earlier DRG validation sample. It is comprised of approximately 60,000 cases per year. We believe this is a sufficient number of cases to both monitor case-mix index changes and PRO performance on payment error reduction.

Recommendation 5C: Although the Benefits Improvement and Protection Act of 2000 improved the equity of the hospital disproportionate share adjustment, Congress still needs to reform this adjustment by:

- Including the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments; and
- Using the same formula to distribute payments to all hospitals covered by prospective payment.

Response: CMS is participating in a Medicare Technical Advisory Group workgroup concerning technical issues related to the collection of uncompensated care data relative to the Medicare disproportionate share formula. A worksheet and instructions to collect these data will be sent out for prior consultation this summer for revisions to the cost reports applicable for cost reporting periods beginning on or after October 1, 2001.

Recommendation 5E: The Congress should protect urban hospitals from the adverse effect of nearby hospitals being reclassified to areas with higher wage indexes by computing each area's wage index as if none of the hospitals located in the area had been reassigned.

Response: In the May 4 proposed rule as in this final rule, CMS includes the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. We agree with MedPAC and believe that this will provide consistency and predictability in hospital reclassification and wage indices.

D. Specialties With Training Beyond the Initial Residency Period (Recommendation 10)

Recommendation: The Congress should eliminate the weighting factors that currently determine Medicare's direct graduate medical education payments and count all residencies equally through completion of residents' first specialty or combined program and subspecialty if one is pursued. Residents training longer than the minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be included in hospitals' direct graduate medical education resident counts. These policy changes should be implemented in a budget-neutral manner through adjustments to the per resident payment amounts.

Response: Currently, Medicare payments to hospitals for direct GME is dependent, in part, on the initial residency period of the residents. Generally, the initial residency period is defined at § 413.86(g)(1) as the minimum number of years required for board eligibility, not to exceed 5 years. For purposes of determining the direct GME payment, residents are weighted at 1.0 FTE within the initial residency period, and at .5 FTE beyond the initial residency period. The limitation on the initial residency period was designed by Congress to limit full Medicare direct GME payment to the time required to train in a single specialty.

MedPAC states that Medicare's current direct GME payment policy of limiting full funding to the first specialty in which a resident trains provides a disincentive for hospitals to offer training in subspecialties or combined programs and, therefore, may influence hospitals' decisions on the types of residents that they train. MedPAC believes that Medicare should not influence workforce policy and recommends that the disincentive be removed to make Medicare payments policies neutral with regard to programs with prerequisites, subspecialties, and combined programs. Accordingly, MedPAC recommends that Congress eliminate the weighting factors associated with direct GME payment so that all residents would be counted for full direct GME payment through the completion of their first specialty, combined program, or subspecialty. Residents training beyond the minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be counted for purposes of the direct GME payment.

MedPAC also believes that eliminating the weighting factors could potentially increase Medicare's direct GME payments by approximately 5 to 8 percent. Therefore, MedPAC recommends that hospitals' per resident amounts (PRAs), which are used to calculate the direct GME payment, be reduced so that this change can be implemented, to the extent possible, in a budget-neutral manner. MedPAC explains that, although further research is needed, it appears that hospitals with substantial subspecialty training (that is, at least 15 percent of the resident mix) would likely see a small net increase in payments, despite the reduction to the PRAs, while hospitals that do not have subspecialty training would likely see a small decrease in payments.

In response to MedPAC's recommendation, we question MedPAC's estimate that eliminating the weighting factors could increase Medicare direct GME payments by only 5 to 8 percent. We believe that subspecialty training constitutes a significant portion of all GME programs, and, consequently, the elimination of the weighting factors could potentially increase payments by far more than 8 percent. If budget neutrality is to be maintained, this could mean that the attendant reductions to the PRAs could be much greater than MedPAC might assume. For those teaching hospitals that have substantial subspecialty training, there is no guarantee that the decreases in the PRAs will be offset by the increases in the direct GME payments due to the elimination of the weighting factors.

While the recommendation would remove the existing disincentive for training in subspecialties, we believe the reductions to the PRAs, whether they are minimal or more significant, will be far more detrimental to the smaller teaching hospitals that have little or no subspecialty training. Many of these hospitals provide care to beneficiaries in rural, underserved areas and in nonhospital settings. We believe these conditions may discourage the expansion of residency training in these areas. It may be inappropriate to limit the direct GME funding to such hospitals, considering Congress' initiatives to encourage residency training in rural, underserved areas and in nonhospital settings. We also are unclear as to how MedPAC would implement the proposed reduction to the PRAs. MedPAC did not explain in

its recommendation how it would propose to do this.

VIII. Other Required Information

A. Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at http://www.hcfa.gov/stats/pubfiles.html. In our May 4, 2001 proposed rule, we published a list of data files that are available for purchase (66 FR 22714–22716).

B. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the May 4, 2001 proposed rule, we solicited public comments on each of these issues for the following sections that contain information collection requirements.

Section 412.230(e)(2)(ii) Criteria for an Individual Hospital Seeking Redesignation to Another Rural Area or an Urban Area; § 412.232(d)(2)(ii) Criteria for All Hospitals in a Rural County Seeking Urban Redesignation; § 412.235 Criteria for All Hospitals in a State Seeking a Statewide Wage Index; and Revised § 412.273 Withdrawing an Application or Terminating an Approved 3-Year Reclassification

Proposed §§ 412.230(e)(2)(ii) and 412.232(d)(2)(ii) specified that, for hospital-specific data for wage index changes for redesignations effective beginning FY 2003, the hospital must provide a 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. For other data, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. Proposed new § 412.235 specifies that in order for all prospective payment system hospitals in a State to use a statewide wage index, the hospitals as a group must submit an application to the MGCRB for a decision for reclassifications for wage index purposes. The proposed changes to § 412.273 incorporated proposed revised procedures for hospitals that request withdraw of their wage index application or termination of their wage index reclassification.

The final versions of these proposed changes, discussed in detail in section IV.G. of this final rule, implement sections 304 (a) and (b) of Public Law 106–554.

The information collection requirements associated with a hospital's application to the MGCRB for geographic reclassifications, including reclassifications for wage index purposes and the required submittal of wage data, that are codified in Part 412 are currently approved by OMB under OMB Approval Number 0938–0573, with an expiration date of September 30, 2002.

Section 412.348(g)(9) Exception Payments

As discussed in section V. of the May 4 proposed rule, Medicare makes special exceptions payments for capital-related costs through the 10th year beyond the end of the capital prospective payment system transition period for eligible hospitals that complete a project that meets certain requirements specified in § 412.348. In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, we proposed to add a new § 412.348(g)(9) to require that hospitals eligible for special exception payments under § 412.348(g) submit documentation to the intermediary indicating the completion date of their project (the date the project was put in use for patient care) that meets the project need and project size requirements outlined in §§ 412.348 (g)(2) through (g)(5). We proposed that, in order for an eligible hospital to receive special exception payments, this documentation would have to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

Because this provision is expected to affect less than 10 hospitals on an annual basis, this requirement is not subject to the PRA as stipulated under 5 CFR 1320.3(c).

In the August 1, 2000 interim final rule with comment period, we solicited public comments on each of these issues for the following section that contains information collection requirements.

Section 412.103(b) Special treatment: Hospitals Located in Urban Areas and That Apply for Reclassification as Rural; Application Requirements

Section 412.103(b) specifies that a facility seeking reclassification under sections 401 (a) or (b) of Public Law 106–113 must apply in writing to the CMS Regional Office and include documentation of the criteria on which its request is based. The application must be mailed; facsimile or other electronic means are not acceptable.

The hospital's application must include a copy of the State law or regulation or other authoritative document verifying that the requesting hospital is situated in an area determined to be rural by the State or the hospital is considered to be a rural hospital.

We estimate that it will take each hospital approximately 30 minutes to complete the application process. We estimate that additional time would be needed to collect the required documentation. This recordkeeping should take no more than approximately 2 hours. Therefore, the paperwork burden associated with the reclassification process would add up to an additional 2½ hours per hospital that request reclassification under section 401 of Public Law 106–113.

This information collection requirement has been submitted to the Office of Management and Budget for approval and is not effective until OMB approves it.

If you have any comments on any of these information collection and recordkeeping requirements, please mail one original and three copies within 30 days of the publication date directly to the following:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group,Division of HCFA Enterprise Standards,Room N2–14–26,7500 Security Boulevard,Baltimore, MD

21244–1850,Attn: John Burke, CMS–1158/31/78–F.

And

Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building,Washington, DC 20503,Attn: Allison Eydt, HCFA Desk Officer.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas,X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordingkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 486

Health professions, Medicare, Organ procurement, X-rays.

Accordingly, 42 CFR chapter IV is amended as follows:

I. The interim final rule with comment period amending 42 CFR Parts 410, 412, 413, 482, and 485 which was published at 65 FR 47026 on August 1, 2000, is adopted as a final rule with the following changes:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END–STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.86 is amended by:

a. Revising the first sentence of the introductory text of paragraphs (g)(11)(i).

b. Revising the first sentence of the introductory text of paragraph (g)(11)(ii).

c. Revising paragraph (g)(11)(v)(C).

§ 413.86 Direct graduate medical education payments.

* * * * *

(g) * * *

(11) * * *

(i) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. * * *

(ii) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. * * *

(v) * * *

(C) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive graduate medical education payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

* * * * *

II. The interim final rule with comment period amending 42 CFR Parts 410, 412, 413, and 485 which was published at 66 FR 32172 on June 13, 2001, is adopted as a final rule with the following changes:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 412.108 is amended by revising paragraph (b) to read as follows:

§ 412.108 Special treatment; Medicare-dependent, small rural hospitals.

* * * * *

(b) *Classification procedures.* The fiscal intermediary determines whether a hospital meets the criterion in paragraph (a) of this section. A hospital must notify its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section. Any hospital that believes it meets this criterion to qualify as an MDH, based on at least two of the three most recent audited cost reporting periods, must submit a written request to its intermediary. The intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. If a hospital disagrees with an intermediary's determination, it should notify its intermediary and submit documentable evidence that it meets the criteria. The intermediary determination is subject to review under subpart R of part 405 of this chapter. MDH status is effective 30 days after the date of written notification of approval. The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for such a review.

* * * * *

III. For the reasons set forth in the preamble to this final rule, 42 CFR Chapter IV is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as set forth below:

1. The authority citation for Part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

2. In § 405.2468, paragraph (f)(6)(ii) is republished and paragraph (f)(6)(ii)(D) is revised to read as follows.

§ 405.2468 Allowable costs.

* * * * *

(f) *Graduate medical education.*

* * *

(6) * * *

(ii) The following costs are not allowable graduate medical education costs—

* * * * *

(D) The costs associated with activities described in § 413.85(h) of this chapter.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section § 412.2 is amended as follows:

a. The introductory text of paragraph (e) is republished.

b. Paragraph (e)(4) is revised.

§ 412.2 Basis of payment.

* * * * *

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid on a reasonable cost basis:

* * * * *

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers.

* * * * *

3. Section 412.23 is amended by adding a new paragraph (i) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(i) *Changes in classification of hospitals.* For purposes of exclusions from the prospective payment system, the classification of a hospital is effective for the hospital's entire cost reporting period. Any changes in the classification of a hospital are made only at the start of a cost reporting period.

4. Section 412.25 is amended by adding a new paragraph (f) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(f) *Changes in classification of hospital units.* For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit's entire cost reporting period. Any changes in the classification of a hospital unit is made only at the start of a cost reporting period.

5. Section 412.63 is amended by revising paragraphs (t) and (u) to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

* * * * *

(t) *Applicable percentage change for fiscal years 2002 and 2003.* The applicable percentage change for fiscal years 2002 and 2003 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 0.55 percentage points for hospitals in all areas.

(u) *Applicable percentage change for fiscal year 2004 and for subsequent fiscal years.* The applicable percentage change for fiscal year 2004 and for subsequent years is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

* * * * *

6. Section 412.92 is amended as follows:

a. Paragraph (b)(1)(iii)(A) is amended by revising the phrase ''50 mile radius'' to read ''35 mile radius''.

b. Paragraph (c)(1) is revised.

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(c) *Terminology.* * * *

(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

* * * * *

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

7. Section 412.105 is amended as follows:

a. The introductory text of paragraph (a) is republished.

b. Paragraph (a)(1) is revised.

c. Paragraph (d)(3)(vi) is revised.

d. A new paragraph (d)(3)(vii) is added.

e. Paragraph (f)(1)(ii)(C) is revised.

f. Paragraph (f)(1)(iii) is revised.

g. Paragraph (f)(1)(v) is amended by adding five sentences at the end.

h. In paragraph (f)(1)(vii), the reference to ''§ 413.86(g)(9)'' is removed and ''§ 413.86(g)(12)'' is added in its place.

i. Paragraph (f)(1)(ix) is revised.

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(a) *Basic data.* CMS determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined under paragraph (b) of this section). Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents. The exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program.

* * * * *

(d) *Determination of education adjustment factor.* * * *

* * * * *

(3) * * *

(vi) For discharges occurring during fiscal year 2002, 1.6.

(vii) For discharges occurring on or after October 1, 2002, 1.35.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* * * *

(1) * * *

(ii) * * *

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.86(f)(3) or § 413.86(f)(4) of this subchapter, as applicable, are met.

(iii)(A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to

more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital listed in paragraph (f)(1)(ii) of this section, to the total time worked by the resident. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(l)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

(B) The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

* * * * *

(v) * * * If a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (f)(l)(v) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, for each new program started, the period of years equals the minimum accredited length for each new program. The period of years for each new program begins when the first resident begins training in each new program. Subject to the provisions of paragraph (f)(1)(ix) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (f)(l)(v) for the receiving hospital for the duration of time that the displaced residents are training at the receiving hospital.

* * * * *

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(ii) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE cap according to the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(iii)(B) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(iii)(A) of this subchapter are met.

* * * * *

8. Section 412.106 is amended by revising the heading of paragraph (e) and paragraph (e)(5) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(e) *Reduction in payments beginning FY 1998.* * * *

(5) For FY 2002, 3 percent.

* * * * *

§ 412.113 [Amended]

9. In § 412.113(c), including the heading for paragraph (c), the term ''hospital'', wherever it appears, is revised to read ''hospital or CAH'' (16 times).

10. Section 412.230 is amended by a new paragraph (a)(5)(v) and revising paragraph (e)(2) to read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) * * *

(5) *Limitations on redesignation.*

* * *

(v) Beginning with wage index reclassification applications for FY 2003, if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application for reclassification to the same area for either the second or third year of the 3-year period, that application will not be approved.

* * * * *

(e) *Use of urban or other rural area's wage index.* * * *

* * * * *

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospital must provide data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(B) For data for other hospitals, the hospital must provide data concerning the average hourly wage in the area in which the hospital is located and the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(C) If the hospital is requesting reclassification under paragraph (e)(1)(iv)(B) of this section, the hospital must provide occupational-mix data to demonstrate the average occupational mix for each employment category in the area to which it seeks reclassification. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

* * * * *

11. Section 412.232 is amended by revising paragraph (d)(2) to read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

* * * * *

(d) *Appropriate data.* * * *

* * * * *

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospitals must provide data from the CMS wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(B) For data for other hospitals, the hospitals must provide the following:

(*1*) The average hourly wage in the adjacent area, which is taken from the CMS hospital wage survey used to

construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(*2*) Occupational-mix data to demonstrate the average occupational mix for each employment category in the adjacent area. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

12. Section 412.235 is added to read as follows:

§ 412.235 Criteria for all hospitals in a State seeking a statewide wage index redesignation.

(a) *General criteria.* For all prospective payment system hospitals in a State to be redesignated to a statewide wage index, the following conditions must be met:

(1) All prospective payment system hospitals in the State must apply as a group for reclassification to a statewide wage index through a signed single application.

(2) All prospective payment system hospitals in the State must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(3) All prospective payment system hospitals in the State must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(4) All hospitals in the State must waive their rights to any wage index classification that they would otherwise receive absent the statewide wage index classification, including a wage index that any of the hospitals might have received through individual geographic reclassification.

(5) New hospitals that open within the State prior to the deadline for submitting an application for a statewide wage index reclassification (September 1), regardless of whether a group application has already been filed, must agree to the use of the statewide wage index as part of the group application. New hospitals that open within the State after the deadline for submitting a statewide wage index reclassification application or during the approved reclassification period will be considered a party to the statewide wage index application and reclassification.

(b) *Effect on payments.*

(1) An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its otherwise redesignated wage index.

(2) Any new prospective payment system hospital that opens in the State during the effective period of an approved statewide wage index reclassification will be designated to receive the statewide wage index for the duration of that period.

(c) *Terms of the decision.*

(1) A decision by the MGCRB on an application for a statewide wage index reclassification will be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals filed a complete application.

(2) The procedures and timeframes specified in § 412.273 apply to withdrawals of applications for redesignation to a statewide wage index and terminations of approved statewide wage index reclassifications, including the requirement that, to withdraw an application or terminate an approved reclassification, the request must be made in writing by all hospitals that are party to the application, except hospitals reclassified into the State for purposes of receiving the statewide wage index.

13. Section 412.273 is amended as follows:

a. The title of the section is revised.

b. Paragraphs (b) and (c) are redesignated as paragraphs (c) and (d), respectively.

c. A new paragraph (b) is added.

d. Redesignated paragraph (c) is revised.

§ 412.273 Withdrawing an application or terminating an approved 3-year reclassification.

* * * * *

(b) *Request for termination of approved 3-year wage index reclassifications.*

(1) A hospital, or a group of hospitals, that has been issued a decision on its application for a 3-year reclassification for wage index purposes only or for redesignation to a statewide wage index and has not withdrawn that application under the procedures specified in paragraph (a) of this section may request termination of its approved 3-year wage index reclassification under the following conditions:

(i) The request to terminate must be received by the MGCRB within 45 days of the publication of the annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

(ii) A request to terminate a 3-year reclassification will be effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year will not be considered.

(2) *Reapplication within the approved 3-year period.*

(i) If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, it may terminate its withdrawal in a subsequent fiscal year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(ii) A hospital may apply for reclassification for purposes of the wage index to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years.

(c) *Written request only.* A request to withdraw an application or terminate an approved reclassification must be made in writing to the MGCRB by all hospitals that are party to the application or reclassification.

* * * * *

14. Section 412.274 is amended by revising paragraph (b) to read as follow:

§ 412.274 Scope and effect of an MGCRB decision.

* * * * *

(b) *Effective date and term of the decision.*

(1) A standardized amount classification change is effective for one year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

(2) A wage index classification change is effective for 3 years beginning with

discharges occurring on the first day (October 1) of the second Federal fiscal year in which the complete application is filed.

* * * * *

15. Section 412.348 is amended by revising paragraph (g)(6) and adding a new paragraph (g)(9) to read as follows:

§ 412.348 Exception payments.

* * * * *

(g) *Special exceptions process.* * * *

(6) *Minimum payment level.*

(i) The minimum payment level for qualifying hospitals will be 70 percent.

(ii) CMS will adjust the minimum payment level in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exceptions process not exceed 10 percent of the total estimated capital prospective payment system payments for the same fiscal year.

* * * * *

(9) *Notification requirement.* Eligible hospitals must submit documentation to the intermediary indicating the completion date of a project that meets the project need requirement under paragraph (g)(2) of this section, the project size requirement under paragraph (g)(5) of this section, and, in the case of certain urban hospitals, an excess capacity test under paragraph (g)(4) of this section, by the later of October 1, 2001 or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as follows:

1. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.70 is amended as follows:

a. Paragraph (a)(1) is republished.

b. A new paragraph (a)(1)(iv) is added.

c. Paragraph (a)(2) is revised.

d. A new paragraph (a)(3) is added.

e. Paragraph (b)(1) is revised.

f. Paragraph (b)(2)(i)(C) is revised.

g. New paragraphs (b)(4), (b)(5) and (b)(6) are added.

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH.*

(1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

* * * * *

(iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2).

(2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(3) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by qualified nonphysician anesthetists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).

(b) *Payment for outpatient services furnished by CAH.*

(1) *General.*

(i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

(2) *Reasonable costs for facility services.*

(i) * * *

(C) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j).

* * * * *

(4) *Costs of emergency room on-call physicians.*

(i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility.

(ii) For purposes of this paragraph (b)(4)—

(A) ''Amounts for reasonable compensation and related costs'' means all allowable costs of compensating emergency room physicians who are on call to the extent the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413. Costs of compensating emergency room physicians are allowable only if the costs are incurred under written contracts that require the physician to come to the CAH when the physician's presence is medically required.

(B) An ''emergency room physician who is on call' means a doctor of medicine or osteopathy with training or experience in emergency care who is immediately available by telephone or radio contact, and is available on site within the timeframes specified in § 485.618(d) of this chapter.

(5) *Costs of ambulance services.*

(i) Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the closest provider or supplier of ambulance services are garaged. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.

(6) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by nonphysician anesthetists employed by the CAH or obtained under

arrangement, payment to the CAH for the costs of those services is made in accordance with § 412.113(c) of this chapter.

* * * * *

3. Section 413.86 is amended as follows:

a. Paragraph (e)(4)(ii)(C)(*1*) is revised.

b. Paragraph (e)(5)(iv) is removed.

c. Paragraph (g)(4) is revised.

d. Paragraph (g)(5) is revised.

e. In paragraph (g)(6), the reference to ''paragraph (g)(9)'' is removed and ''paragraph (g)(12)'' is added in its place.

f. Paragraph (g)(8) is revised.

§ 413.86 Direct graduate medical education payments.

* * * * *

(e) *Determining per residents amounts for the base period.* * * *

(4) * * *

(ii) * * *

(C) *Determining necessary revisions to the per resident amount.* * * *

(*1*) *Floor.* (*i*) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(*ii*) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 85 percent of the locality-adjusted national average per resident amount for FY 2002.

(*iii*) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

* * * * *

(g) *Determining the weighted number of FTE residents.* * * *

(4) For purposes of determining direct graduate medical education payments—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this paragraph (g), the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit), for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) For purposes of determining direct graduate medical education payment—

(i) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(iii) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(iv) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(5) based on the equivalent of 12-month cost reporting periods.

(v) If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph (g)(6) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (g)(5) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (g)(5), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(vi) Subject to the regulations at paragraph (g)(8) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (g)(5) for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

* * * * *

(8) *Closure of hospital or hospital residency program.*

(i) *Definitions.* For purposes of this paragraph (g)(8)—

(A) ''Closure of a hospital'' means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(B) ''Closure of a hospital residency training program'' means the hospital ceases to offer training for residents in a particular approved medical residency training program.

(ii) *Closure of a hospital.* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(A) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) *Closure of a hospital's residency training program.* If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (g)(8)(iii)(B) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (g)(8)(iii)(A) of this section are met.

(A) *Receiving hospital(s).* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(*1*) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(*2*) No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (g)(8)(iii)(B)(*2*) of this section.

(B) *Hospital that closed its program(s).* A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(*1*) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(*2*) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Act (42 U.S.C. 1302 and 1395hh).

2. Section 485.610 is amended by revising paragraphs (a)(2)(ii) and (b) and adding a new paragraph (c) to read as follows:

§ 485.610 Condition of participation: Status and location.

(a) * * *

(2) * * *

(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or

* * * * *

(b) *Standard: Location in a rural area or treatment as rural.* The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section.

(1) The CAH meets the following requirements:

(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under § 412.62(f) of this chapter;

(ii) The CAH is not deemed to be located in an urban area under § 412.63(b) of this chapter; and

(iii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under § 412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under § 412.232 of this chapter.

(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with § 412.103 of this chapter.

(c) *Standard: Location relative to other facilities or necessary provider certification.* The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.

3. Section 485.639 is amended by revising paragraph (b) to read as follows:

§ 485.639 Condition of participation: Surgical services.

* * * * *

(b) *Anesthetic risk and evaluation.*

(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

* * * * *

4. Section 485.643 is amended by revising paragraph (f) to read as follows:

§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

* * * * *

(f) For purposes of these standards, the term ''organ'' means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

F. Part 486 is amended as follows:

1. The authority citation for Part 486 continues to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 486.302 is amended by revising the definition of ''organ'' to read as follows:

§ 486.302 Definitions.

* * * * *

''Organ'' means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: July 23, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2001.

Tommy G. Thompson,

Secretary.

Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.

Addendum—Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2001 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2001

I. Summary and Background

In this Addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 2001, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate. Section 213 of Public Law 106–554 amended section 1886(b)(3) of the Act to allow all SCHs to rebase their hospital-specific rate based on their FY 1996 cost per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2002. The changes, to be applied prospectively, affect the calculation of the Federal rates. In section III. of this Addendum, we finalize changes to the prospective payment rates for inpatient operating costs for FY 2001, as set forth in the June 13, 2001 interim final rule with comment period. In section IV. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2002. Section V. of this Addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2002. The tables to which we refer in the preamble to this final rule are presented at the end of this Addendum in section VI.

II. Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2002

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes will be effective with discharges occurring on or after October 1, 2001.

In summary, the standardized amounts set forth in Tables 1A and 1C of section VI. of this Addendum reflect—

- Updates of 2.75 percent for all areas (that is, the market basket percentage increase of 3.3 percent minus 0.55 percentage points);
- An adjustment to ensure budget neutrality as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 2001 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 2001 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(B) and (d)(2)(C) of the Act required us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education (IME) costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are revising the discharge-weighted national standardized amount for Puerto Rico to

reflect the proportion of discharges in large urban and other areas from the FY 2000 MedPAR file.

2. Computing Large Urban and Other Area Averages

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in large urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on 1999 population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2002. These areas are identified in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban areas' and the other areas' average standardized amounts for FY 2002 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVII) of the Act as amended by section 301 of Public Law 106–554 specifies that the update factor for the standardized amounts for FY 2002 is equal to the market basket percentage increase minus 0.55 percentage points for hospitals in all areas. Section 301 also established that the update factor for FY 2003 is equal to the market basket percentage increase minus 0.55 percentage points. We are revising § 412.63 to reflect these changes.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2002 is 3.3 percent. Thus, for FY 2002, the update to the average standardized amounts equals 2.75 percent for hospitals in all areas.

As in the past, we are adjusting the FY 2001 standardized amounts to remove the effects of the FY 2001 geographic reclassifications and outlier payments before applying the FY 2002 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2002.

Although the update factors for FY 2002 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2002 for both prospective payment hospitals and hospitals excluded from the prospective payment system.

We have included our final recommendations on the update factors in Appendix C to this final rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used FY 2000 discharge data to simulate payments and compared aggregate payments using the FY 2001 relative weights and wage index to aggregate payments using the FY 2002 relative weights and wage index. The same methodology was used for the FY 2001 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.995821. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.997209. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2001 budget neutrality adjustments. For FY 2001, we used an average of the budget neutrality factor that was in effect from October 1, 2000 through March 30, 2001 and the budget neutrality factor that was in effect from April 1, 2001 through September 30, 2001 (0.997225 and 0.997122, respectively). We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we will continue to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2001. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare

Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2000 discharge data to simulate payments, and compared total prospective payments (including IME and disproportionate share hospital (DSH) payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.990675 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2001 budget neutrality adjustment factor. We note that the proposed FY 2002 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 28, 2001, and the effects of section 304 of Public Law 106–554 to extend wage index reclassifications for 3 years. The effects of any additional reclassification changes that occurred as a result of appeals and reviews of the MGCRB decisions for FY 2002 or from a hospital's request for the withdrawal of a reclassification request for FY 2002 are reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in this final rule.

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

i. FY 2002 outlier thresholds. For FY 2001, the fixed loss cost outlier threshold published in the August 1, 2000 final rule was equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $17,550 ($16,036 for hospitals that have not yet entered the prospective payment system for capital-related costs). As a result of the change made by Public Law 106–554 to the update factor for the operating standardized amounts, this threshold was applicable for discharges on or after October 1, 2000 and before April 1, 2001. For discharges occurring on or after April 1, 2001 and before October 1, 2001, the threshold was equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs). The revision to the threshold was discussed in the interim final rule with comment period published on June 13, 2001 (66 FR 32176). (In the June 13, 2001 interim final rule with comment period, the fixed loss amount was stated as $16,500. This was an error; the correct amount is $16,350. This is the amount that has been applied to discharges since April 1, 2001, in the PRICER software used to determine payments.) The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

For FY 2002, we proposed to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $21,000. The capital prospective payment system is fully phased in, effective FY 2002. Therefore, we no longer are establishing a separate threshold for hospitals that have not yet entered the prospective payment system for capital-related costs. We proposed to maintain the marginal cost factor for cost outliers at 80 percent.

In this final rule, we are establishing a fixed loss cost outlier threshold equal to the prospective rate for the DRG plus the IME and DSH payment plus $21,025. In addition, we are maintaining the marginal cost factor for cost outliers at 80 percent. To calculate the final FY 2002 outlier thresholds, we simulated payments by applying FY 2002 rates and policies to the March 2001 update of the FY 2000 MedPAR file and the March 2001 update of the Provider-Specific File.

We apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 2000, we used a cost inflation factor of zero percent. For FY 2001, we used a cost inflation factor (or cost adjustment factor) of 1.8 percent. To set the proposed FY 2002 outlier thresholds, we used a 2-year cost inflation factor of 5.5 percent (to inflate FY 2000 charges to FY 2002). We are using a cost inflation factor of 2.8 percent per year to set the final FY 2002 outlier thresholds (this equates to a 2-year cost inflation factor of 5.7 percent). This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 2000 is higher than we projected before the beginning of FY 2000, and that the percentage of actual outlier payments for FY 2001 will likely be higher than we projected before the beginning of FY 2001. The calculations of ''actual'' outlier payments are discussed further below.

Comment: Several commenters noted that the proposed threshold was almost 20 percent higher than the threshold effective for FY 2001. The commenters believed that we should verify the amount of cost outliers paid in a year and reconcile accordingly. One commenter also suggested that we amend our method of calculating the threshold so that the threshold is set at a level that reflects FY 2001 threshold plus a reasonable updating factor to account for inflation.

Response: As indicated in the proposed rule, and as explained in numerous previous **Federal Register** documents, under the policy we have maintained since the inception of the hospital inpatient prospective payment system for operating costs, we do not make retroactive adjustments to reconcile differences between the percentage of outlier payments projected before a given fiscal year and the ''actual'' outlier payments for that fiscal year.

In accordance with section 1886(d)(5)(A) of the Act, we set outlier thresholds for an upcoming fiscal year so that outlier payments for the fiscal year are projected to equal a specified percentage between 5 and 6 percent of total payments based on DRG prospective payment rates. To set the thresholds, we simulate payments using the best available data. We believe that the methodology suggested by the commenter, simply updating the FY 2001 thresholds to account for inflation,

would not be appropriate because, among other reasons, the methodology would not reflect the use of the most recent complete data with respect to discharges and costs. The difference between the FY 2001 outlier thresholds and the FY 2002 outlier thresholds arises from differences reflected in the data used to set the respective thresholds.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the FY 2002 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2002 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.8 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2002 were as follows:

	Operating standardized amounts	Capital federal rate
National	0.948910	0.974711
Puerto Rico	0.942593	0.970336

Based on simulations of payments using updated data, the final outlier adjustment factors applied to the standardized amounts for FY 2002 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948928	0.942440
Puerto Rico	0.974762	0.970140

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 2001 outlier adjustment factors on the standardized amounts.

Table 8A in section VI. of this Addendum contains the updated statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These statewide average ratios replace the ratios published in the August 1, 2000 final rule (65 FR 47054). Table 8B contains comparable statewide average capital cost-to-charge ratios. These average ratios will be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.1903547 or greater than 1.3148656 and capital cost-to-charge ratios lower than 0.0119230 or greater than 0.1677417. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2002 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 2000 and FY 2001 outlier payments. In the August 1, 2000 final rule (65 FR 47054), we stated that, based on available data, we estimated that actual FY 2000 outlier payments would be approximately 6.2 percent of actual total DRG payments. This was computed by simulating payments using the March 2000 update of the FY 1999 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 2000 bills but instead reflected the application of FY 2000 rates and policies to available FY 1999 bills. Our current estimate, using available FY 2000 bills, is that actual outlier payments for FY 2000 were approximately 7.6 percent of actual total DRG payments. We note that the MedPAR file for FY 2000 discharges continues to be updated. Thus, the data indicate that, for FY 2000, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2000 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2000). In fact, the data indicate that the proportion of actual outlier payments for FY 2000 exceeds 6.0 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 2000.

We currently estimate that actual outlier payments for FY 2001 will be approximately 6.2 percent of actual total DRG payments, 1.1 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2001. This estimate is based on simulations using the March 2001 update of the Provider-Specific File and the March 2001 update of the FY 2000 MedPAR file (discharge data for FY 2000 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2001 by applying FY 2001 rates and policies to available FY 2000 bills.

5. FY 2002 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A contains the two national standardized amounts that are applicable to all hospitals, except hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

Comment: Several commenters were unable to reconcile the standardized amounts published in the proposed rule for FY 2002 with the rates which were in effect for FY 2001. These commenters requested that we clarify, by category, the increases and decreases applied to the standardized amounts in the proposed rule in order to illustrate the method under which the rates were established.

Response: The confusion likely arises from the two different rates that were effective during FY 2001. Prior to the passage of Public Law 106–554, section 1886(b)(3)(B)(i) of the Act set the update to the standardized amounts for FY 2001 as the market basket percentage increase minus 1.1 percentage points. Section 301(a) of Public Law 106–554 revised section 1886(b)(3)(B)(i) of the Act to set the update to the standardized amounts for FY 2001 equal to the full market basket percentage increase.

Further, section 301(b) of Public Law 106–554 included a special provision to implement the full market basket update for purposes of making payments for FY 2001 only. Under this special provision, for discharges occurring on or after October 1, 2000 and before April 1, 2001, the update factor (other than for SCHs) is equal to the market basket percentage increase minus 1.1

percentage points. For discharges occurring on or after April 1, 2001 and before October 1, 2001, the update factor (other than SCHs) is equal to the market basket percentage increase plus 1.1 percentage points.

However, section 547 of Public Law 106–554 makes this special rule applicable solely to payments in FY 2001 and the payment increases under section 301(b) in this fiscal year are not to be taken into account in developing payments for future fiscal years. Consequently, when we established the rates for FY 2002, we based the calculation on FY 2001 standardized amounts reflecting the full FY 2001 market basket percentage increase of 3.4 percent. Since the standardized amounts calculated using the full market basket were not actually used for payment during FY 2001, they were not published in either the August 1, 2000 final rule or the June 13, 2001 interim final rule with comment period.

To arrive at the final FY 2002 standardized amounts, we updated the standardized amounts through FY 2001 using the full market basket of 3.4 percent (without applying a geographic budget neutrality factor or outlier factor), then multiplied this amount by: the update factor for FY 2002; the wage and recalibration budget neutrality factor; the geographic reclassification budget neutrality factor; and the outlier factor established for FY 2002. The calculation below details this reconciliation process using the large urban area standardized amount as an example. Although the commenters requested a reconciliation of the proposed rates, the example below reconciles the final FY 2002 rates, as those are the amounts actually in effect for the fiscal year. To reconcile the rates in the proposed rule, the exact same methodology applies.

EXAMPLE OF THE CALCULATION OF THE FY 2002 FINAL STANDARDIZED AMOUNT FOR LARGE URBAN AREAS

	Labor	Nonlabor
FY 2001 Standardized Amount with Full Market Basket Update/No Reclassification, Budget Neutrality or Outlier Offset	$3,072.51	$1,248.88
Update Factor: (Market Basket Percentage Increase minus 0.55 percent)	1.0275	1.0275
FY 2002 Wage Index and DRG reclassification/recalculation budget neutrality factor	0.995821	0.995821
FY 2002 Reclassification budget neutrality factor	0.990675	0.990675
Outlier Factor	0.948928	0.948928
Final Rate for FY 2002 (after multiplying FY 2001 base rate by above factors)	$2,955.44	$1,201.30

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of this preamble, we discuss the data and methodology for the FY 2002 wage index. The wage index is set forth in Tables 4A, 4B, 4C, and 4F of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2002, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we will use for discharges occurring in FY 2002. These factors have been recalibrated as explained in section II. of the preamble.

D. Calculation of Prospective Payment Rates for FY 2002

General Formula for Calculation of Prospective Payment Rates for FY 2002

The prospective payment rate for all hospitals located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate.

The prospective payment rate for SCHs equals whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal rate. Section 213 of Public Law 106–554 amended section 1886(b)(3) of the Act to allow all SCHs to rebase their hospital-specific rate based on their FY 1996 cost per discharge.

The prospective payment rate for MDHs equals 100 percent of the Federal rate, or, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 100 percent of the Federal rate plus 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

The prospective payment rate for Puerto Rico equals 50 percent of the

Puerto Rico rate plus 50 percent of a discharge-weighted average of the Federal large urban standardized amount and the Federal other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 2001 and before October 1, 2002, except for SCHs, MDHs, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate. The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Table 1A in section VI. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section VI. of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 cost per discharge, the FY 1987 cost per discharge or, for qualifying SCHs, the FY 1996 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082).

a. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2002

We are increasing the hospital-specific rates by 2.75 percent (the hospital market basket percentage increase minus 0.55 percentage points) for SCHs and MDHs for FY 2002. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2002, is the market basket rate of increase minus 0.55 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2002, is the market basket rate of increase minus 0.55 percentage points.

b. Calculation of Hospital-Specific Rate

For SCHs, the applicable FY 2002 hospital-specific rate is based on the following: the hospital-specific rate calculated using the greater of the FY 1982 or FY 1987 costs, increased by the applicable update factor; or, if the hospital-specific rate based on cost per case in FY 1996 is greater than the hospital-specific rate using either the FY 1982 or the FY 1987 costs, the greater of 50 percent of the hospital-specific rate based on the FY 1982 or FY 1987 costs, increased by the applicable update factor, or 50 percent of the Federal rate plus 50 percent of its rebased FY 1996 hospital-specific rate updated through FY 2002. For MDHs, the applicable FY 2002 hospital-specific rate is calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor, which is the same as the update for all prospective payment hospitals. In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by 0.995821) as discussed in section II.A.4.a. of this Addendum. The resulting rate is used in determining the payment rate an SCH or MDH is paid for its discharges beginning on or after October 1, 2001.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2001 and Before October 1, 2002

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI. of the Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI. of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI. of the Addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Changes to the Prospective Payment Rates for Inpatient Operating Costs for FY 2001 (Section 301 of Public Law 106–554 and 42 CFR 412.63(s))

In the June 13, 2001 interim final rule with comment period, we implemented section 301(a) of Public Law 106–554 as it applied to FY 2001. Section 301(a) amended section 1886(b)(3)(B)(i) of the Act by changing the percentage increase for the hospital inpatient payment rates

for FYs 2001, 2002, and 2003. Previously, section 1886(b)(3)(B)(i) (as amended by section 406 of Public Law 106–113) established the update factor to the payment rates for inpatient prospective payment system hospitals (other than SCHs, who received the full market basket update effective October 1, 2000) as the market basket percentage increase minus 1.1 percent for FYs 2001 and 2002; the update factor for FY 2003 and subsequent fiscal years was established as the full market basket percentage increase. Section 301(a) of Public Law 106–554 amended section 1886(b)(3)(B)(i) of the Act and changed the update factor for FY 2001 to the full market basket percentage increase. (Section 301(a) also revised the update factors that apply to FYs 2002 and 2003, as discussed in section II. of this Addendum.) Prior to enactment of Public Law 106–554, the update factor for FY 2002 was the market basket percentage increase minus 1.1 percentage points and the update factor for FY 2003 was the full market basket percentage increase. Section 301(a) of Public Law 106–554 amended section 1886(b)(3)(B)(i) of the Act to revise the update factor for FYs 2002 and 2003 to be the market basket percentage increase minus 0.55 percentage points.

Further, section 301(b) of Public Law 106–554 provided a special rule to implement the full market basket update to inpatient hospital prospective payment rates for FY 2001. Under this special rule, for discharges occurring on or after October 1, 2000 and before April 1, 2001, the update factor for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket percentage increase minus 1.1 percentage points. For discharges occurring on or after April 1, 2001 and before October 1, 2001, the update factor for the payment rates for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket percentage increase plus 1.1 percentage points. Section 547 of Public Law 106–554 makes this special rule applicable solely to payments in FY 2001 and the payment increases resulting for FY 2001 are not taken into account in developing payments for future fiscal years.

As directed by the special rule in section 301(b) of Public Law 106–554, any discharges occurring on or after October 1, 2000, and before April 1, 2001, are paid in accordance with the standardized amounts set forth in the FY 2001 hospital inpatient prospective payment system final rule published in the August 1, 2000 **Federal Register** (65 FR 47126). These rates were calculated using the market basket percentage increase of 3.4 percent minus 1.1 percentage points, for a 2.3 percent increase (see 65 FR 47112), as directed by section 1886(b)(3)(B)(i) of the Act prior to the passage of Public Law 106–554.

To implement the special rule under section 301(b) of Public Law 106–554, in the June 13 interim final rule with comment period, we recomputed the standardized amounts effective for discharges occurring on or after April 1, 2001. That is, we replaced the update factor of 2.3 percent applied to the standardized amounts in the August 1, 2000 final rule, with the update factor of 4.5 percent (the market basket percentage increase plus 1.1 percentage points, or 3.4 plus 1.1 percentage points).

	Large urban areas		Other areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	2,900.64	1,179.02	2,900.64	1,179.02
Puerto Rico	1,402.79	564.66	1,380.58	555.72
SCHs	2,895.02	1,176.74	2,849.20	1,158.11

A. Budget Neutrality

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are projected to be the same as those that would have been made without such adjustments. Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are projected to be the same as those that would have been made without the change in the wage index.

Finally, under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that final aggregate payments under the prospective payment system are projected to equal the aggregate prospective payments that would have been made absent the geographic reclassification provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act.

The distributive effects on hospital payments of the IME and DSH changes also included in Public Law 106–554 required us to recalculate the budget neutrality factors that are required by section 1886(d)(8)(D) of the Act.

As we stated in the June 13, 2001 interim final rule with comment period, the budget neutrality factors that were used to establish the standardized amounts effective for discharges occurring on or after October 1, 2000 were: 0.997225 for the DRG reclassification and recalibration and updated wage index (65 FR 47112); and 0.993187 for geographic reclassification (65 FR 47113). Using the same methodology that was used to calculate the budget neutrality factors in the August 1, 2000 final rule, the corresponding budget neutrality factors for the standardized amounts effective for discharges occurring on or after April 1, 2001 and before October 1, 2001 are 0.997122 and 0.993279. The FY 2001 budget neutrality factor for Puerto Rico did not change. Therefore, the budget neutrality factor for Puerto Rico as published in the August 1, 2000 **Federal Register** (65 FR 47112) remained in effect for discharges occurring on or after April 1, 2001 and before October 1, 2001.

B. Outliers

In accordance with section 1886(d)(3)(B) of the Act, which directs the Secretary to adjust the national standardized amounts to account for the estimated proportion of total payments made to outlier cases, the fixed-loss outlier threshold was also revised as a result of the change made by Public Law 106–554 to the update factor for the operating standardized amounts. For discharges occurring on or after April 1, 2001 and before October 1, 2001, we established a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus IME and

DSH payments, plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs). (In the June 13, 2001 interim final rule with comment period, the fixed loss amount was stated as $16,500. This was an error. The correct amount is $16,350. This is the amount that has been applied to discharges since April 1, 2001, in the PRICER software used to determine payments.) In determining the outlier threshold, we used the same methodology employed to determine the outlier threshold for FY 2001 (65 FR 47113 through 47114). Outlier payments for discharges occurring on or after October 1, 2000 and before April 1, 2001, will be determined in accordance with the standardized amounts and outlier thresholds set forth in the FY 2001 final rule published in the August 1, 2000 **Federal Register** (65 FR 47113).

Although the market basket percentage used to update SCHs was not revised by Public Law 106–554, the standardized amounts applied to these hospitals for discharges occurring on or after April 1, 2001 and before October 1, 2001 also increase slightly. This increase in SCH rates is due to the budget neutrality factors effective for this portion of the fiscal year.

For discharges occurring on or after April 1, 2001 and before October 1, 2001, the outlier adjustment factors are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948929	0.937854
Puerto Rico	0.973671	0.967355

III. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2002

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate rate and the hospital-specific rates for FY 2002. The rates, which will be effective for discharges occurring on or after October 1, 2001. As we stated in section V. of the preamble of this final rule, we are no longer determining an update to the capital hospital-specific rate, since FY 2001 is the last year of the 10-year transition period, and beginning in FY 2002 all hospitals (except ''new'' hospitals under § 412.324(b)) will be paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of Public Law 105–33, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the model is still used to estimate the regular exceptions payment adjustment and other factors. The model and its application are described in greater detail in Appendix B of this final rule.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

In the August 1, 2000 final rule (65 FR 47122), we established a Federal rate of $382.03 for FY 2001. In the June 13, 2001 interim final rule with comment, as a result of implementing section 301(b) of Public Law 106–554, we established a Federal rate of $380.85 for discharges occurring on or after April 1, 2001 and before October 1, 2001 (66 FR 32180). (See section V.E. of the preamble and section III.A.5 of this Addendum for a fuller discussion of the provisions of section 301(b) of Public Law 106–554.) In accordance with section 547 of Public Law 106–554, the special payment increases provided by Public Law 106–554 effective between

April and October 2001 do not apply for discharges occurring after FY 2001 and are not taken into account in determining the payment rates in subsequent years. Thus, the adjustments and rates published in the August 1, 2000 final rule were used in determining the FY 2002 capital rates. As a result of the changes to the factors used to establish the Federal rate in this addendum, the FY 2002 Federal rate is $390.74.

In the discussion that follows, we explain the factors that were used to determine the FY 2002 Federal rate. In particular, we explain why the FY 2002 Federal rate has increased 2.28 percent compared to the FY 2001 Federal rate (published in the August 1, 2000 final rule (65 FR 47122)). We also estimate aggregate capital payments will increase by 4.27 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly less than last year (5.48 percent) because with the end of the transition period the remaining hold harmless hospitals receiving ''cost-based'' payments will begin being paid based on 100 percent of the Federal rate.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment system are estimated to increase in FY 2002 compared to FY 2001.

1. Standard Federal Rate Update

Under § 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor for FY 2002 under that framework of 1.1 percent, based on data available at that time. Under the update framework, the final update factor for FY 2002 is 1.3 percent. This update factor is based on a projected 0.7 percent increase in the CIPI, a 0.3 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2000 DRG reclassification and recalibration, and a forecast error correction of 0.3 percent. We explain the basis for the FY 2002 CIPI projection in section II.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2000 DRG reclassification and recalibration as part of our FY 2002 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2002, we are projecting a 1.0 percent increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2002. Therefore, the net adjustment for case-mix change in FY 2002 is 0.0 percentage points.

We estimate that FY 2000 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update recommendation for FY 2002.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.3 percentage points was calculated for the FY 2000 update. That is, current historical data indicate that the forecasted FY 2000 CIPI used in calculating the FY 2000 update factor (0.6 percent) understatethe actual realized price increases (0.9 percent) by 0.3 percentage points. This under-prediction was due to prices from municipal bond yields declining slower than expected. Therefore, we are making a 0.0 3 percent adjustment for forecast error in the update for FY 2002.

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

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination

of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2002, we have developed a Medicare-specific intensity measure based on a 5-year average, using FY 1996 through 2000 data. In determining case-mix constant intensity, we found that observed case-mix increase was 1.6 percent in FY 1996, 0.3 percent in FY 1997, −0.4 percent in FY 1998, and −0.3 in FY 1999, and −0.7 percent in FY 2000. Since we found an increase in case-mix of 1.6 for FY 1996, which was outside of the range of 1.0 to 1.4 percent, we estimate that real case-mix increase was 1.0 to 1.4 percent for that year. The estimate of 1.0 to 1.4 percent is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1996 through FY 2000. Based on this analysis, we believe that all of the observed case-mix increase for FY 1997, FY 1998, and FY 1999, and FY 2000 is real. The increases for FY 1996 was in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. Based upon an upper limit of 1.0 percent real case-mix increase, we estimate that case-mix constant intensity increased by an average 0.3 percent during FYs 1996 through 2000, for a cumulative increase of 1.4 percent, given estimates of real case-mix of −1.0 percent for FY 1996, 0.3 percent for FY 1997, −0.4 for FY 1998, and −0.3 for FY 1999, and −0.7 percent for FY 2000. Based upon an upper limit of 1.4 percent real case-mix increase, we estimate that case-mix constant intensity declined increase by an average 0.2 percent during FYs 1996 through 2000, for a cumulative increase of 1.2 percent, given that real case-mix increase was 1.4 percent for FY 1996, 0.3 percent for FY 1997, −0.4 for FY 1998, −0.3 for FY 1999, and −0.7 percent for FY 2000. Since we estimate that intensity has increased during that period, we are recommending a 0.3 percent intensity adjustment for FY 2002.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related prospective payment system payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2000 final rule, we estimated that outlier payments for capital in FY 2001 would equal 5.91 percent of inpatient capital-related payments based on the Federal rate (65 FR 47121). Accordingly, we applied an outlier adjustment factor of 0.9409 to the Federal rate. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital will equal 5.76 percent of inpatient capital-related payments based on the Federal rate in FY 2002. Therefore, we are establishing an outlier adjustment factor of 0.9424 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2002 is lower than the percentage for FY 2001.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. As explained previously, in accordance with section 547 of Public Law 106–554, the FY 2002 rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). Therefore, the net change in the outlier adjustment to the Federal rate for FY 2002 is 1.0016 (0.9424/0.9409). The outlier adjustment increases the FY 2002 Federal rate by 0.16 percent compared with the FY 2001 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B of this final rule, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 2001, we calculated a GAF/DRG budget neutrality factor of 0.9979. In the proposed rule for FY 2002, we proposed a GAF/DRG budget neutrality factor of 0.9913. In this final rule, based on calculations using updated data, we are applying a factor of 0.9934. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. As explained previously, in accordance with section 547 of Public Law 106–554, the FY 2002 adjustments and rates are based on the FY 2001 adjustment and rates published in the August 1, 2000 final rule (65 FR 47122). The incremental change in the adjustment from FY 2001 to FY 2002 is 0.9934. The cumulative change in the rate due to this adjustment is 0.9927 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001 and the incremental factor for FY 2002:0.9980 ×1.0053 ×0.9998 ×0.9994 ×0.9987 ×0.9989 ×1.0028 ×0.9985 ×0.9979 ×0.9934 =0.9927).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also

incorporates the effects on the GAF of FY 2002 geographic reclassification decisions made by the MGCRB compared to FY 2001 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total capital payments payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the regular exceptions payment adjustment factor. We describe that model in Appendix B to this final rule. An adjustment for regular exceptions is necessary for determining the FY 2002 rates because we will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001 but ending in FY 2002, in accordance with § 412.312(c)(3). In FY 2003 and later, no payments will be made under the regular exceptions provision, and then we will only compute a budget neutrality adjustment under § 412.348(d) for special exceptions. We describe the methodology to determine the special exceptions adjustment in section V.D. of this final rule. For FY 2002, the exceptions adjustment is a combination of the adjustment that would be made under the regular exceptions provision and under the special exceptions provision under § 412.348(g).

For FY 2001, we estimated that exceptions payments would equal 2.15 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9785 (1—;0.0215) in determining the Federal rate. In the May 4, 2001 proposed rule, we estimated that regular exceptions payments for FY 2002 would equal 0.63 percent of aggregate payments based on the Federal rate, we estimated that special exceptions payments for FY 2002 would equal 0.12 percent of aggregate payments based on the Federal rate. Therefore, we estimated that total exceptions payments for FY 2002 would equal 0.75 percent (0.63 + 0.12 = 0.75) of aggregate payments based on the Federal rate, and we proposed an exceptions payment reduction factor of 0.9925 (1—;0.0075) to the Federal rate for FY 2002. The proposed exceptions reduction factor for FY 2002 was 1.43 percent higher than the factor for FY 2001 published in the August 1, 2000 final rule.

For this final rule, based on updated data, we estimate that regular exceptions payments for FY 2002 will equal 0.59 percent of aggregate payments based on the Federal rate, and we estimate that special exceptions payments for FY 2002 will equal 0.12 percent of aggregate payments based on the Federal rate. We estimate that total exceptions payments for FY 2002 will be 0.71 percent (0.59 + 0.12 = 0.71). Thus, the FY 2002 exceptions payment reduction factor is 0.9929 (1—0.0071). The exceptions reduction factor for FY 2002 is 1.47 percent higher than the factor for FY 2001 published in the August 1, 2000 final rule. This increase is primarily due to the expiration of the regular exceptions provision and the narrowly defined nature of the special exceptions policy.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. As explained previously, in accordance with section 547 of Public Law 106–554, the FY 2002 adjustments and rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). Therefore, the net adjustment to the FY 2002 Federal rate is 0.9929/0.9785, or 1.0147.

5. Standard Capital Federal Rate for FY 2002

For FY 2001, the capital Federal rate was $382.03 for discharges occurring between October 1, 2000 and April 1, 2001. As a result of implementing section 301(b) of Public Law 106–554, for discharges occurring from April to October 2001, the capital Federal rate was $380.85. However, as explained previously, in accordance with section 547 of Public Law 106–554, the FY 2002 adjustments and rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). As a result of changes we are making to the factors used to establish the Federal rate, in this final rule we are establishing the capital Federal rate for FY 2002 of $390.74. The Federal rate for FY 2002 was calculated as follows:

- The FY 2002 update factor is 1.0130; that is, the update is 1.30 percent.
- The FY 2002 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9934.
- The FY 2002 outlier adjustment factor is 0.94214.
- The FY 2002 (regular and special) exceptions payments adjustment factor is 0.9929.

Since the Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we have made no additional adjustments in the standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2002 affected the computation of the FY 2002 Federal rate in comparison to the FY 2001 Federal rate. The FY 2002 update factor has the effect of increasing the Federal rate by 1.30 percent compared to the FY 2001 rate published in the August 1, 2000 final rule, while the geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.66 percent. The FY 2002 outlier adjustment factor has the effect of increasing the Federal rate by 0.16 percent compared to the FY 2001 rate published in the August 1, 2000 final rule. The FY 2002 (regular and special) exceptions reduction factor has the effect of increasing the Federal rate by 1.47 percent compared to the exceptions reduction for FY 2001. The combined effect of all the proposed changes is to increase the Federal rate by 2.28 percent compared to the Federal rate for FY 2001.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2001 FEDERAL RATE AND FY 2002 FEDERAL RATE

	FY 2001	FY 2002	Change	Percent change
Update factor[1]	1.0090	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor[1]	0.9979	0.9934	0.9934	−0.66
Outlier Adjustment Factor[2]	0.9409	0.9424	1.0016	0.16

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2001 FEDERAL RATE AND FY 2002 FEDERAL RATE—Continued

	FY 2001	FY 2002	Change	Percent change
Exceptions Adjustment Factor[2]	0.9785	0.9929	1.0147	1.47
Federal Rate	$382.03	$390.74	1.0228	2.28

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2000 to FY 2001 resulting from the application of the 0.9934 GAF/DRG budget neutrality factor for FY 2001 is 0.9934.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2001 outlier reduction factor is 0.9424/0.9409, or 1.0016.

As stated previously in this section, the FY 2002 Federal rate has increased 2.28 percent compared to the FY 2001 capital Federal rate as a result of the FY 2002 factors and adjustments applied to the capital Federal rate. Specifically, the capital update factor increased the capital Federal rate 1.30 percent over FY 2001. The exceptions reduction factor increased 1.47 percent from 0.9875 to 0.9929 for FY 2002, which results in an increase to the capital Federal rate for FY 2002. Also, the outlier adjustment factor increased 0.16 percent from 0.9409 for FY 2001 to 0.9424 for FY 2002, which results in an increase to the capital Federal rate in FY 2002 compared to FY 2001. The GAF/DRG adjustment factor decreased 0.66 percent from 0.9979 for FY 2001 to 0.9934 for FY 2002, which results in a decrease the capital Federal rate for FY 2002 compared to FY 2001. The effect of all these changes is a 2.28 percent increase in the FY 2002 capital Federal rate compared to FY 2001.

We are also providing a chart that shows how the final FY 2002 capital Federal rate differs from the proposed FY 2002 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2002 PROPOSED FEDERAL RATE AND FY 2002 FINAL FEDERAL RATE

	Proposed FY 2002	Final FY 2002	Change	Percent change
Update factor	1.0110	1.0130	1.0020	0.20
GAF/DRG Adjustment Factor	0.9913	0.9934	1.0021	0.21
Outlier Adjustment Factor	0.9426	0.9424	0.9998	−0.02
Exceptions Adjustment Factor	0.9925	0.9929	1.0004	0.04
Federal Rate	$389.09	$390.74	1.0042	0.42

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended rate. The GAF is calculated using the operating prospective payment system wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 0.9899, while the DRG adjustment is 0.9967, for a combined cumulative adjustment of 0.9866.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of Public Law 105–33.

For FY 2001, before application of the GAF, the special rate for Puerto Rico hospitals was $185.06. As explained previously, in accordance with section 547 of Public Law 106–554, the FY 2002 adjustments and rates are based on the FY 2001 rates published in the August 1, 2000 final rule. With the changes we proposed to the factors used to determine the rate, the proposed FY 2002 special rate for Puerto Rico was $188.67. In this final rule, based on the final factors, the FY 2002 capital rate for Puerto Rico is $187.73.

7. Changes in the Capital Prospective Payment System Rates for FY 2001

In the June 13, 2001 interim final rule with comment period, we implemented section 301(b) of Public Law 106–554 (66 FR 32180).

Section 301(b) of Public Law 106–554 provided a special rule to implement the full market basket update to inpatient hospital operating prospective payment rates for FY 2001. Under this special rule, for discharges occurring on or after October 1, 2000 and before April 1, 2001, the update factor for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket percentage increase minus 1.1 percentage points. For discharges occurring on or after April 1, 2001 and before October 1, 2001, the update factor for the payment rates for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket percentage increase plus 1.1 percentage points. Section 547 of Public Law 106–554 makes this special rule applicable solely to payments in FY 2001, and the payment increases resulting for FY 2001 are not taken into

account in developing payments for future fiscal years.

As directed by the special rule in section 301(b) of Public Law 106–554, any discharges occurring on or after October 1, 2000, and before April 1, 2001, will be paid in accordance with the standardized amounts set forth in the FY 2001 hospital inpatient prospective payment system final rule published in the August 1, 2000 **Federal Register** (65 FR 47126). These rates were calculated using the market basket percentage increase of 3.4 percent minus 1.1 percentage points, for a 2.3 percent increase (see 65 FR 47112), as directed by section 1886(b)(3)(B)(i) of the Act, prior to the passage of Public Law 106–554.

As stated in the June 13, 2001 interim final rule with comment period, to implement the special rule under section 301(b) of Public Law 106–554, we recomputed the standardized amounts effective for discharges occurring on or after April 1, 2001. That is, we replaced the update factor of 2.3 percent applied to the standardized amounts in the August 1, 2000 final rule, with the update factor of 4.5 percent (the market basket percentage increase plus 1.1 percentage point, or 3.4 plus 1.1 percentage points).

As published in the June 13, 2001 interim final rule with comment period (66 FR 32180), the revised capital Federal rate for discharges occurring on or after April 1 2001, and before October 1, 2001, are shown in the table below.

FINAL FY 2001 CAPITAL RATES

[Effective April 1, 2001 to October 1, 2001]

National Rate	$380.85
Puerto Rico Rate	$184.61

Section 1886(d)(3)(B) of the Act directs the Secretary to adjust the inpatient operating national standardized amounts to account for the estimated proportion of operating DRG payments made to payments in outlier cases. Accordingly, as a result of this change to the update to the operating standardized amounts for discharges occurring on or after April 1, 2001, and before October 1, 2001, we revised the fixed-loss outlier thresholds. The regulations at § 412.312(c) establish a unified outlier methodology for inpatient operating and inpatient capital-related costs, which utilizes a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital prospective payment system payments. Because operating DRG payments increased as a result of section 301 of Public Law 106–554, we decreased the fixed-loss threshold. The decrease in the outlier threshold also results in an increase in the estimated outlier payments for capital from 5.91 percent to 6.21 percent. Thus, the capital national outlier adjustment factor was revised from 0.9409 (as specified in the August 1, 2000 final rule (65 FR 47121)) to 0.9379 (as specified in the June 13, 2001 interim final rule with comment period).

As stated earlier, the basic methodology for determining the capital Federal rate is set forth in §§ 412.308 through 412.352. Although the operating update to the standardized amounts was affected by section 301 of Public Law 106–554, the standard capital Federal rate update remained unchanged (0.9 percent). The exceptions adjustment factor was determined based on an estimate of the ratio of exception payments to total capital payments. As a result of the fixed-cost outlier threshold, which affects total capital payments, in order to maintain budget neutrality for exception payments, we revised the exception adjustment factor from 0.9785 to 0.9787. The national GAF/DRG budget neutrality factor was also revised from 0.9979 to 0.9978. The Puerto Rico GAF/DRG budget neutrality factor remained unchanged (1.0037). Accordingly, as a result of the revisions to the capital outlier reduction factor and the capital exceptions adjustment factor, for discharges occurring on or after April 1, 2001, and before October 1, 2001, the national capital Federal rate was revised from $382.03 (65 FR 47127) to $380.85 and the Puerto Rico capital rate was revised from $185.06 (65 FR 47127) to $184.61.

In accordance with § 412.328(e), the hospital-specific rate is determined using the update factor and the exceptions adjustment factor. As a result of revising the exceptions adjustment factor to account for the change to the fixed-loss outlier threshold resulting from the special payment rule for FY 2001 provided for under section 301(b) of Public Law 106–554, for discharges occurring on or after April 1, 2001, and before October 1, 2001, the cumulative net adjustment to the hospital-specific rate was revised from 1.0147 (65 FR 47124) to 1.0145. For discharges occurring on or after April 1, 2001, and before October 1, 2001, the hospital-specific rate was determined by multiplying the FY 2000 hospital-specific rate by the cumulative net adjustment of 1.0145.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2002

With the end of the capital prospective payment system transition period, all hospitals (except ''new'' hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2002, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted Federal rate.

Hospitals also may receive outlier payments for those cases that qualifyFY under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2002 are in section II.A.4.c. of this Addendum. For FY 2002, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $21,025.

During the capital prospective payment system transition period, a hospital also may receive an additional payment under the regular exceptions process through its cost reporting period beginning before October 1, 2001, but ending in FY 2002 if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348(c). Under § 412.348(d), the amount of a regular exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its

cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

An eligible hospital may qualify for a special exception payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent, and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment level. This amount is offset by (1) any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital prospective payment system; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. The minimum payment level is 70 percent for all eligible hospitals under § 412.348(g).

New hospitals, as defined under § 412.300, are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990, or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation through the remainder of the transition period, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, American Hospital Association (AHA) data, and Securities Data Company data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent discussion of the cost category weights in the CIPI was in the final rule with comment period for FY 1998 published on August 29, 1997 (62 FR 46050).

2. Forecast of the CIPI for Federal Fiscal Year 2002

We are forecasting the CIPI to increase 0.7 percent for FY 2002. This reflects a projected 1.4 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.3 percent increase in other capital expense prices in FY 2002, partially offset by a 2.0 percent decline in vintage-weighted interest rates in FY 2002. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or hospital unit, a rehabilitation hospital or hospital unit, or a long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts adjusted to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the update factor for a hospital or unit depends on the hospital's or hospital unit's costs in relation to the ceiling for the most recent cost reporting period for which information is available. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2002 for hospitals and hospital units excluded from the prospective payment system is 3.3 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2002 would be between 0.8 and 3.3 percent, or 0 percent, depending on the

hospital's or unit's costs in relation to its rate-of-increase limit.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1998, and before October 1, 2002, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class.

Section 1886(b)(3)(H) of the Act, as amended by section 121 of Public Law 106–113, provides for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. On August 1, 2000, we published an interim final rule with comment period that implemented this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000 (65 FR 47026) and a final rule that implemented the provision for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001 (65 FR 47054). This final rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2001.

As discussed in section VI. of the preamble of this final rule, the cap on the target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap (the labor-related portion of costs equals 0.71553 and the nonlabor-related portion of costs equals 0.28447). A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the wage index under the hospital inpatient prospective payment system (see § 412.63), without taking into account reclassifications under sections 1886(d)(8)(B) and (d)(10) of the Act.

As discussed in section VI. of the preamble of this final rule, we have made an adjustment to the caps on target amounts for new and existing excluded hospitals and units. In calculating the wage-adjusted caps on target amounts for new and existing excluded and units for FY 2001, we inadvertently made an error. In wage neutralizing FY 1996 target amounts, we used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585 through 41593), which is based on wage data after taking into account geographic reclassifications under section 1886(d)(8) of the Act. We have used pre-reclassified wage data in our recalculation of the caps for FY 2002. We recalculated both the limits for new excluded hospitals and units and the caps for existing excluded hospitals and units, using the same wage index used under the prospective payment system for skilled nursing facilities (SNF) as shown in Table 7 of the July 30, 1999 SNF final rule (64 FR 41690). We do not anticipate a significant impact on overall payments to these hospitals and units.

Section 307(a) of Public Law 106–554 amended section 1886(b)(3) of the Act to provide for a 2-percent increase to the wage-adjusted 75th percentile cap on the target amount for long-term care hospitals, effective for cost reporting periods beginning during FY 2001. This provision is applicable to long-term care hospitals that were subject to the cap for existing excluded hospitals and units, as specified in § 413.40(c).

In addition to the increase to the cap on the target amounts for long-term care hospitals, section 307(a) of Public Law 106–554 amended section 1886(b)(3)(A) of the Act to make the section applicable to all long-term care hospitals, effective for cost reporting periods beginning during FY 2001. This provision requires a revision to the determination of each long-term care hospital's FY 2001 target amount as specified in § 413.40(c)(4). For cost reporting periods beginning during FY 2001, the hospital-specific target amount otherwise determined for a long-term care hospital as specified under § 413.40(c)(4)(ii) is multiplied by 1.25 (that is, increased by 25 percent). However, the revised FY 2001 target amount for a long-term care hospital cannot exceed its wage-adjusted national cap as required by section 1886(b)(3) of the Act, as amended by section 307(a) of Public Law 106–554.

For cost reporting periods beginning in FY 2002, in the May 4, 2001 proposed rule, we included the following proposed caps:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,404	$ 3,341
Rehabilitation	$15,689	$6,237
Long-Term Care	$31,399	$12,483

In this final rule, using updated data, we have recalculated the proposed caps for cost reporting periods beginning in FY 2002. The final FY 2002 caps are listed below:

Class of excluded hospital or unit	Labor-related shae	Nonlabor-related share
Psychiatric	$8,429	$3,351
Rehabilitation	$15,736	$6,256
Long-Term Care	$31,490	$12,519

Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 and 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, and 8B are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2000 (1996 Wage Data), 2001 (1997 Wage Data) and 2002 (1998 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages
Table 3A—FY 2002 and 3-Year Average Hourly Wage for Urban Areas
Table 3B—FY 2002 and 3-Year Average Hourly Wage for Rural Areas
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4F—Puerto Rico Wage Index and Capital Geographic –Adjustment Factor (GAF)
Table 4G—Pre-Reclassified Wage Index for Urban Areas
Table 4H—Pre-Reclassified Wage Index for Rural Areas
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected –Percentile Lengths of Stay FY 2000 MedPAR Update 3/01 –GROUPER V18.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2000 MedPAR Update 3/01 GROUPER V19.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) July 2001
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) July 2001

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large Urban Areas		Other Areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,955.44	$1,201.30	$2,908.65	$1,182.27

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large Urban Areas		Other Areas	
	Labor	Nonlabor	Labor	Nonlabor
National PR	$2,929.57	$1,190.78	$2,929.57	$1,190.78
Puerto Rico	1,420.07	571.61	1,397.59	562.56

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$390.74
Puerto Rico	187.73

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
010001	15.8484	16.4088	17.4467	16.5711
010004	15.0194	17.9732	19.0010	17.1863
010005	16.2615	17.5985	18.6554	17.4986
010006	17.3081	16.7480	17.6115	17.2150

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
010007	14.8048	15.4798	15.6788	15.3288
010008	17.6549	14.7443	17.4728	16.6080
010009	17.5328	18.7731	18.4979	18.2633
010010	15.9090	16.4468	16.4664	16.2848
010011	20.6261	20.7972	22.4292	21.2601
010012	19.2992	17.7171	15.8686	17.5430
010015	18.3461	15.4510	19.1178	17.5372
010016	16.1311	17.2473	20.2198	17.8844
010018	18.9617	17.6449	18.9388	18.5180
010019	15.4910	16.3493	17.0856	16.3311
010021	14.6297	16.2919	15.1241	15.3000
010022	20.5050	18.5879	17.6435	18.8422
010023	16.2581	16.1025	16.3209	16.2283
010024	16.0263	16.2900	15.9034	16.0692
010025	14.5311	15.1356	15.1548	14.9441
010027	14.9278	11.7900	16.8595	14.1053
010029	16.4103	17.6461	18.3605	17.4403
010031	18.0194	18.7835	18.6402	18.4877
010032	12.6540	12.5995	15.3590	13.6017
010033	19.6797	20.3923	21.2986	20.4581
010034	14.7342	15.0959	15.3639	15.0606
010035	17.4788	20.1853	15.9439	17.6916
010036	17.2880	17.8140	17.7166	17.6061
010038	18.3309	18.2671	19.6098	18.7632
010039	18.8080	20.1045	20.3406	19.7778
010040	19.1030	18.9376	20.0983	19.3415
010043	16.2022	30.7489	18.6640	19.9982
010044	17.0229	22.0091	24.0265	20.8906
010045	15.0065	15.2200	17.0417	15.7248
010046	17.1822	17.3970	18.9737	17.8750
010047	16.3803	13.3521	15.4190	15.2030
010049	14.4823	14.7590	15.5246	14.9487
010050	15.4159	18.5163	17.9830	17.2796
010051	9.9390	11.9275	11.8108	11.1940
010052	13.8649	16.5486	18.0653	16.1248
010053	13.1778	14.6267	15.5649	14.5406
010054	17.1246	18.5103	19.4955	18.4846
010055	18.1930	18.9526	18.8590	18.6711
010056	19.0783	19.2175	19.6577	19.3204
010058	12.7809	16.1702	16.9715	15.1274
010059	18.1886	19.1286	18.8020	18.7124
010061	15.9215	14.9547	14.5003	15.1112
010062	13.5690	14.7732	12.3259	13.5151
010064	20.8966	20.4139	19.5256	20.2712
010065	15.6357	16.4049	16.8752	16.3279
010066	12.0681	15.4317	13.1559	13.4757
010068	18.7367	12.0525	18.6925	15.8875
010069	13.5684	13.8636	14.7211	14.0429
010072	14.3481	14.9526	16.2339	15.1957
010073	12.8328	13.8601	14.1273	13.6015
010078	17.7110	17.9202	18.1363	17.9248
010079	16.8701	16.4421	17.0648	16.7882
010080	13.8473	*	*	13.8473
010081	16.9823	18.9474	17.2996	17.7081
010083	16.2146	16.8933	18.0312	17.0916
010084	18.7794	18.4965	18.7769	18.6812
010085	18.8696	18.4744	19.9023	19.0736
010086	14.9255	16.6694	16.5711	16.0968
010087	18.3889	19.0033	18.0567	18.5192
010089	16.6090	16.8042	17.7800	17.0521
010090	18.1121	18.3866	18.9445	18.4882
010091	16.3620	13.9405	17.0799	15.6820
010092	16.4980	16.9900	17.8144	17.1322

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
010094	18.5603	*	*	18.5603
010095	11.8993	12.4525	12.2597	12.2090
010097	12.8955	13.0413	12.7286	12.8889
010098	14.2787	15.9165	14.0300	14.6833
010099	15.9309	15.9874	15.5619	15.8073
010100	15.4826	17.2011	17.9430	16.9229
010101	15.4173	15.3859	14.4625	15.0781
010102	12.7251	13.7933	13.8136	13.4259
010103	19.3115	17.9358	17.7242	18.3325
010104	18.0997	17.7126	16.8457	17.5501
010108	20.7914	17.9017	19.4617	19.3047
010109	14.0870	15.3107	14.6752	14.6907
010110	15.9066	15.6317	15.8283	15.7917
010112	15.1056	15.1401	16.8271	15.6716
010113	17.2440	16.9683	16.8936	17.0309
010114	17.2612	15.2454	17.0760	16.4722
010115	13.7524	14.6268	14.2261	14.2120
010118	16.6889	18.8477	17.0834	17.5145
010119	18.1707	18.8024	19.3942	18.9605
010120	17.0332	17.2336	18.2567	17.5146
010121	15.1806	14.6444	14.5262	14.8160
010123	18.1604	16.7344	19.2140	17.9949
010124	16.2666	16.2846	16.7465	16.4273
010125	14.4153	15.5304	16.0136	15.3557
010126	17.6405	19.5710	19.1065	18.7347
010127	19.6095	19.5190	18.2786	19.1726
010128	12.5747	14.5056	14.4322	13.6385
010129	14.4267	14.7286	16.1733	15.1385
010130	16.3465	16.6809	19.5573	17.3907
010131	17.9076	17.8260	20.1883	18.6602
010134	10.7817	18.8835	19.9856	15.8677
010137	15.9348	12.1217	20.5828	15.9236
010138	12.1295	12.8675	14.5254	13.1763
010139	19.9487	19.0001	20.4331	19.7578
010143	15.7144	16.7911	17.6212	16.7651
010144	17.1211	17.1320	18.2040	17.4771
010145	20.7460	20.8434	20.5895	20.7209
010146	18.8561	18.5198	19.1415	18.8309
010148	14.6443	12.2214	15.8349	13.9784
010149	17.0836	18.6333	18.0156	17.9216
010150	16.9749	17.8951	18.9359	17.9332
010152	17.3835	17.8306	18.7677	18.0088
010155	16.7028	9.0300	15.0689	12.5183
010158	*	17.3227	18.3957	17.8637
020001	27.9690	28.1747	28.0394	28.0627
020002	26.9145	24.5815	25.1987	25.5092
020004	26.3979	30.5667	25.4679	27.5927
020005	29.0068	30.2920	29.2378	29.5337
020006	26.7706	31.2404	28.1417	28.8630
020007	24.9555	27.8319	32.3852	28.0097
020008	30.4712	29.4146	30.8691	30.2487
020009	23.1801	20.1930	18.4660	20.3801
020010	18.6417	23.6727	22.7559	21.4818
020011	29.4697	30.4727	28.0658	29.3006
020012	23.9259	24.8543	25.5320	24.7635
020013	26.8172	23.8847	28.1557	26.0576
020014	24.0932	27.3823	24.5875	25.3179
020017	24.9714	26.8319	28.0572	26.6405
020024	22.7263	24.0872	25.3205	24.0621
020025	27.1529	21.7557	20.2583	22.6334
030001	19.8695	20.3673	21.7869	20.6506
030002	21.6263	21.5977	21.8375	21.6886
030003	23.6722	23.4833	22.6804	23.3063

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
030004	17.7333	14.0711	15.5478	15.4308
030006	17.6409	18.2668	20.0273	18.6274
030007	18.5602	19.6708	21.5169	19.9379
030008	*	22.2758	22.2190	22.2524
030009	17.9343	18.1794	18.7557	18.2786
030010	18.7997	19.0907	19.5123	19.1422
030011	20.0784	19.2973	19.4310	19.5785
030012	19.4245	18.9918	20.6585	19.6997
030013	21.0182	20.7458	20.0535	20.5870
030014	19.4697	19.9315	19.7966	19.7342
030016	20.5606	19.3967	19.4785	19.8559
030017	20.4185	22.8765	21.7938	21.6805
030018	18.9115	20.2032	20.8980	20.0193
030019	19.9211	21.7005	21.2540	20.9846
030022	15.7886	19.2966	19.5794	17.6713
030023	22.4365	23.6697	24.1678	23.4686
030024	21.6692	22.2541	23.6009	22.5290
030025	17.6759	12.7254	11.9894	13.7385
030027	17.5796	15.7554	17.6555	16.9563
030030	21.6249	20.8303	21.6932	21.3795
030033	16.8396	20.0044	20.2820	18.9069
030034	19.0868	16.8241	20.8689	18.8279
030035	19.7153	19.2781	20.0226	19.6580
030036	18.9449	20.7567	21.6371	20.4743
030037	21.4376	22.8266	23.7615	22.6712
030038	22.0777	22.6776	22.9822	22.5885
030040	17.9722	18.5456	19.7636	18.7537
030041	17.4389	15.8921	18.8717	17.2718
030043	20.7721	20.9341	20.5598	20.7468
030044	16.4654	16.8649	17.6575	17.0214
030047	19.6916	22.6401	21.4412	21.2271
030049	19.0896	19.0881	19.3580	19.1639
030054	14.4861	15.3338	15.0657	14.9801
030055	18.2751	16.3613	20.2991	18.2684
030059	21.7100	24.0465	22.6279	22.7570
030060	16.7661	19.2461	18.6313	18.2043
030061	17.3470	18.9063	19.9047	18.7238
030062	17.4825	17.6738	18.7172	17.9978
030064	18.5391	19.5673	20.3837	19.5213
030065	19.9277	20.5130	20.7838	20.4254
030067	15.6207	14.4446	17.2778	15.7364
030068	17.3482	17.3614	17.7208	17.4823
030069	19.0013	19.0961	21.0936	19.7255
030080	19.9865	20.5144	20.6581	20.3684
030083	23.6433	23.3355	23.5229	23.4991
030085	17.8402	21.0954	20.8690	19.9451
030086	18.5030	19.5436	*	19.0352
030087	20.0469	21.4084	21.9465	21.1838
030088	19.5772	19.8682	20.5340	20.0152
030089	19.9018	20.4019	20.9516	20.4404
030092	21.5628	20.6986	21.8308	21.3646
030093	19.4688	19.7262	20.4314	19.9052
030094	19.4773	21.6218	22.8123	21.4086
030095	14.2499	13.7293	13.7664	13.9087
030099	18.0747	16.1541	18.2263	17.4781
030100	*	*	23.7609	23.7609
030101	*	*	19.2547	19.2547
030102	*	*	18.2413	18.2413
040001	15.5735	15.1624	16.9178	15.8741
040002	14.0865	13.0592	15.1107	14.0333
040003	14.0027	14.2089	15.5740	14.5731
040004	17.2926	17.8476	17.9034	17.6718
040005	12.8825	13.2597	11.1318	12.3937

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
040007	19.5299	21.9583	18.6998	19.9568
040008	12.6974	15.3040	14.7985	14.3087
040010	17.6231	18.6023	19.4913	18.6031
040011	12.2654	14.5319	16.0995	14.1756
040014	15.3853	17.6340	18.1434	17.0051
040015	14.6045	16.5891	15.5207	15.5649
040016	17.5431	19.0295	20.2321	18.9152
040017	14.9533	13.5098	15.4736	14.6592
040018	17.5602	17.6027	18.7463	17.9749
040019	25.7080	22.6769	23.4163	23.8479
040020	14.8059	16.4827	18.9844	16.6335
040021	16.4628	17.6398	19.6835	17.8176
040022	16.0006	17.0397	20.8281	17.7640
040024	15.7282	14.4541	17.6607	15.9615
040025	10.9496	11.5079	13.4705	11.8847
040026	18.2398	19.5563	19.7924	19.1863
040027	14.5406	16.0975	17.4431	16.0716
040028	12.8409	14.6584	13.9946	13.7921
040029	17.7777	17.8787	21.1370	18.9480
040030	14.1541	13.5428	11.2402	12.7784
040032	13.3280	13.7030	13.2872	13.4471
040035	11.2123	12.8300	10.9569	11.6408
040036	17.9080	18.9757	20.2012	19.0415
040037	13.4815	14.6559	14.0941	14.0704
040039	13.8386	14.3576	14.7177	14.3115
040040	17.4283	18.0895	19.1984	18.2668
040041	13.3613	15.9896	16.4624	15.2103
040042	14.6641	15.2142	15.2057	15.0333
040044	11.4422	12.6275	13.3501	12.5381
040045	18.7724	14.9429	16.2469	16.4870
040047	16.3948	16.8654	17.5336	16.9538
040048	15.8203	*	*	15.8203
040050	11.7934	13.3818	14.0036	13.0341
040051	16.2803	15.8627	16.6039	16.2390
040053	15.8193	16.3610	15.0219	15.7502
040054	15.0412	15.3219	14.2577	14.8844
040055	16.1029	17.1269	18.0414	17.0866
040058	15.6706	17.6766	16.4278	16.6344
040060	11.4686	12.8148	17.9805	13.6105
040062	17.2757	18.2048	17.8902	17.8204
040064	12.4007	10.7255	11.5029	11.4801
040066	17.6429	18.3377	19.7144	18.5416
040067	13.4930	14.6014	14.4741	14.1956
040069	16.1147	17.5052	17.0026	16.8681
040070	15.4757	16.9027	16.9700	16.4358
040071	16.3022	16.9610	17.6144	16.9553
040072	15.8425	16.0895	17.4960	16.4940
040074	17.3819	18.3224	18.7542	18.1968
040075	12.7496	13.3623	14.0975	13.3977
040076	18.5512	19.0732	20.5840	19.3801
040077	12.4625	12.9211	13.9114	13.0965
040078	17.8573	18.7600	18.5821	18.4100
040080	15.7397	19.2461	19.3707	18.0636
040081	10.6791	11.3169	11.1332	11.0311
040082	16.5127	16.2152	15.1331	15.9302
040084	17.2469	17.2613	17.7295	17.4070
040085	15.7765	16.8957	16.5216	16.3838
040088	15.6710	17.9636	17.1624	16.9372
040090	17.5503	17.8282	19.0824	18.0989
040091	17.0444	19.8700	20.1378	18.8893
040093	12.9010	12.3537	13.9741	13.0114
040100	14.9688	14.7587	15.6833	15.1704
040105	14.2409	15.3319	14.3896	14.6616

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
040106	15.4000	15.6545	18.1341	16.4515
040107	19.6184	18.8120	17.8628	18.6841
040109	13.9807	14.6266	16.6278	15.0815
040114	18.3133	18.8743	21.1231	19.3828
040116	19.5695	20.2716	*	19.9151
040118	17.4300	19.3720	18.2123	18.3407
040119	15.3847	15.5338	16.9407	15.9572
040124	17.2547	19.1349	19.2889	18.5723
040126	11.6845	12.5368	11.6517	11.9404
040132	13.1760	17.5179	10.3875	13.4483
040134	*	18.0787	19.0185	18.5701
040135	*	22.6761	23.0084	22.8797
050002	27.6006	37.8295	36.9630	33.5586
050006	19.5272	19.5594	18.2061	19.0382
050007	29.5398	30.7126	30.8676	30.4910
050008	25.8570	26.2458	26.3682	26.1654
050009	26.2506	26.8159	28.4734	27.2303
050013	24.8541	23.2201	28.0569	25.1985
050014	24.5302	22.8478	23.6745	23.6450
050015	25.3838	26.2481	27.7731	26.4938
050016	20.1542	20.5566	21.2045	20.6377
050017	23.6639	23.9625	25.6178	24.4113
050018	14.6622	15.4721	15.2903	15.1444
050021	28.5003	25.8966	*	27.2682
050022	22.9583	24.0318	24.5254	23.8802
050024	20.3427	21.3989	22.4274	21.4070
050025	21.9952	23.3896	24.8245	23.3764
050026	28.6850	27.8736	23.1904	26.4206
050028	16.4531	16.4671	17.6138	16.8496
050029	23.2911	25.1259	24.6839	24.3441
050030	21.0096	20.9812	21.5621	21.1955
050032	22.5868	25.2010	24.3598	24.0616
050033	24.5609	24.9328	32.0179	27.2378
050036	20.4703	21.2420	21.8239	21.1856
050038	27.8274	28.6528	29.9698	28.8293
050039	22.2524	22.7117	22.8288	22.6033
050040	30.6664	32.1287	30.2607	31.0150
050042	22.2343	24.8067	24.5260	23.8317
050043	33.2286	32.9958	33.8255	33.3456
050045	20.7307	19.8831	21.1474	20.5973
050046	31.3831	25.3185	25.2005	27.4555
050047	29.4412	29.9255	29.9580	29.7840
050051	17.8401	17.8945	18.7809	18.1179
050054	19.3686	20.7212	22.0982	20.7075
050055	29.0872	29.3984	29.2730	29.2593
050056	23.8507	27.4321	23.8396	24.9757
050057	21.7581	21.1554	20.7420	21.1969
050058	25.7261	23.1641	23.3009	23.9601
050060	20.9219	20.7747	20.5450	20.7207
050061	23.7443	23.5454	24.5488	23.9503
050063	23.0724	24.8851	25.7593	24.5061
050065	21.1848	24.0420	24.6290	23.1479
050066	21.4187	16.5725	16.1649	17.6784
050067	21.3029	23.1966	25.8857	23.3989
050068	28.4804	20.6851	19.3615	22.4409
050069	29.2980	25.9420	24.6153	26.4351
050070	32.5964	32.5166	34.0721	33.0817
050071	33.1379	33.1850	34.4367	33.6139
050072	32.9660	33.2858	39.7321	35.2928
050073	34.6111	33.3922	32.8555	33.5664
050075	33.5246	33.9095	33.7160	33.7090
050076	33.8835	27.7797	33.9752	31.7128
050077	23.2986	24.1019	24.1404	23.8541

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050078	22.8023	23.0736	24.3150	23.3638
050079	34.4253	33.2432	30.0167	32.3461
050082	21.7004	22.1009	23.7617	22.5498
050084	23.0966	23.5866	25.4517	24.0054
050088	24.0634	20.8406	24.9641	23.1779
050089	20.0194	20.9117	22.8450	21.2533
050090	23.8969	23.4097	24.6070	23.9625
050091	22.2220	25.2792	23.7713	23.6457
050092	15.3841	16.7969	17.1211	16.4241
050093	24.0837	25.2130	25.6647	24.9860
050095	33.3761	33.6718	30.4847	32.6392
050096	21.6752	20.0487	22.7394	21.3870
050097	22.6147	16.7054	22.5991	20.1968
050099	24.2921	24.8091	25.3722	24.8349
050100	30.0552	29.8758	25.2031	28.1754
050101	30.0132	31.0264	31.8957	30.9871
050102	21.2947	22.2937	24.0014	22.4745
050103	25.3384	24.7932	25.4133	25.1832
050104	25.4407	25.5797	26.9726	25.9841
050107	21.7649	21.2690	22.2019	21.7497
050108	25.2116	23.5564	25.1758	24.5678
050109	26.4768	*	*	26.4768
050110	20.1769	20.1870	19.9589	20.1175
050111	21.7397	21.5487	20.7897	21.3840
050112	26.2922	25.3015	26.8182	26.1335
050113	27.7805	28.8420	28.5224	28.4025
050114	25.9073	24.7286	26.6757	25.7599
050115	21.0499	21.3291	23.0182	21.8124
050116	25.5919	25.2130	24.9196	25.2412
050117	20.4379	23.3612	22.2123	21.9903
050118	23.9976	23.7698	23.7129	23.8243
050121	18.8818	19.5252	18.7272	19.0416
050122	*	26.3172	26.9546	26.6358
050124	23.0193	22.7736	24.5069	23.3667
050125	24.0434	29.6147	32.0230	28.3742
050126	23.8424	23.9247	24.6752	24.1448
050127	19.7654	22.1937	20.9027	20.9520
050128	24.1801	25.7240	26.6132	25.5185
050129	27.1586	26.5030	24.0108	25.7227
050131	29.0570	31.0732	32.5462	30.8106
050132	22.9139	24.0834	24.0173	23.6527
050133	24.4011	24.9746	23.2093	24.1354
050135	27.0341	23.2361	24.7157	24.9796
050136	24.4336	24.7921	24.7280	24.6450
050137	30.0725	32.6507	32.9192	31.8970
050138	37.4088	37.3286	38.1584	37.6483
050139	31.3785	32.9351	31.4984	31.9286
050140	33.6644	34.1499	32.7609	33.4990
050144	25.7483	27.8751	27.4069	26.9409
050145	33.0620	32.3857	34.5185	33.3152
050148	21.0584	21.9211	20.0971	20.9748
050149	23.3754	24.6078	26.8674	24.8666
050150	23.4777	24.9073	24.6596	24.3771
050152	27.7504	34.0766	33.3305	31.5833
050153	29.5915	30.5714	32.3389	30.8441
050155	22.9420	21.0257	25.3354	22.9852
050158	27.9789	27.5623	28.6071	28.0313
050159	25.2105	23.2912	22.5313	23.6099
050167	21.6778	21.9128	21.8796	21.8226
050168	25.2504	23.3511	25.1937	24.5830
050169	24.6361	22.3888	24.8407	23.8796
050170	22.1989	23.9574	24.3654	23.4164
050172	17.6976	20.1841	19.6120	19.1630

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050173	23.3255	24.5545	24.8694	24.1923
050174	31.2136	30.2140	30.2775	30.5443
050175	27.7875	27.2806	24.7548	26.2477
050177	20.2485	21.7943	21.1396	21.0728
050179	19.2861	21.7175	23.8868	21.4573
050180	32.1883	31.8947	33.3257	32.5107
050183	19.9765	20.3638	*	20.1665
050186	21.9062	22.4155	23.6288	22.6119
050188	27.4364	28.0918	28.2364	27.9460
050189	23.2415	22.8687	27.4071	24.6245
050191	26.7297	20.8321	25.3516	24.1885
050192	17.8095	18.6701	14.1996	16.5873
050193	23.7260	22.6316	24.9444	23.7567
050194	28.2701	29.7371	29.5678	29.1714
050195	34.7789	35.5621	36.9068	35.7823
050196	16.6866	18.5180	18.2411	17.8430
050197	31.4513	35.7449	32.4030	33.0882
050204	24.3944	23.6105	22.7099	23.5849
050205	21.1545	23.6831	24.1691	23.0778
050207	20.8576	21.6214	22.9941	21.8243
050211	31.2175	31.6084	31.7280	31.5153
050213	20.7338	21.4806	21.4951	21.1847
050214	20.8704	21.7335	24.0276	22.1888
050215	28.4058	29.8563	35.0459	31.0290
050217	19.8913	19.6010	20.2042	19.9076
050219	25.4730	21.7444	21.2458	22.6404
050222	27.0713	27.4809	23.3563	25.7959
050224	23.7942	23.5316	23.5101	23.6043
050225	20.7978	23.3480	21.6820	21.9144
050226	26.9297	27.7315	24.4443	26.2380
050228	30.3772	34.0711	34.2596	32.7722
050230	25.3640	27.7357	26.6291	26.5638
050231	25.5798	26.1508	26.7321	26.1759
050232	23.3849	24.3072	24.5245	24.0793
050233	31.3954	*	*	31.3954
050234	28.5188	25.7035	24.6126	26.2702
050235	25.8595	25.2527	27.0922	26.0726
050236	26.2723	26.9803	25.9458	26.4027
050238	24.0043	24.2922	24.5823	24.2994
050239	20.4071	22.6625	23.2711	22.0940
050240	25.2540	26.3657	26.7620	26.0528
050241	27.2198	26.3740	29.8345	27.7426
050242	30.1432	31.1576	32.0829	31.1145
050243	22.9123	28.9635	26.4627	26.1049
050245	24.3969	23.8124	23.2716	23.7873
050248	27.4214	26.2015	27.6457	27.0910
050251	18.4990	21.6574	23.6360	21.1907
050253	20.0658	16.0701	16.7540	17.4281
050254	19.6899	19.3126	20.1176	19.7146
050256	23.5302	23.6887	23.4835	23.5723
050257	19.5923	15.2306	17.2596	17.1813
050260	23.5201	23.2421	27.4234	24.5032
050261	20.4496	20.0552	20.1040	20.2029
050262	29.0054	28.8785	29.5550	29.1532
050264	29.4542	32.1312	36.0331	32.4545
050267	24.7464	26.2264	26.0401	25.6690
050270	23.7260	24.0439	25.3757	24.3521
050272	21.4374	22.4247	23.0587	22.2948
050274	21.1943	20.0422	*	20.6204
050276	28.5051	29.8624	33.3302	30.5715
050277	22.3125	20.0520	26.0822	22.5131
050278	23.8434	24.7787	23.9289	24.1853
050279	21.0570	20.8444	21.8949	21.2309

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050280	24.4267	25.2149	25.6651	25.1337
050281	18.5907	19.6888	24.2251	20.7934
050282	24.4593	28.8261	25.4428	26.2214
050283	27.8763	29.7734	31.7669	30.1598
050286	17.8045	16.5708	19.4241	17.6805
050289	26.7185	34.1393	30.4750	30.2632
050290	26.3745	28.6231	29.6796	28.2631
050291	26.4908	30.2748	29.4029	28.6899
050292	22.4878	21.6243	20.8410	21.6183
050293	19.1761	22.2963	24.1875	21.4642
050295	20.7393	21.2892	21.7883	21.2665
050296	25.3166	27.2948	28.3906	27.0098
050298	20.5181	24.4477	23.2006	22.6781
050299	25.7697	26.4543	25.5035	25.9187
050300	22.7423	23.5116	25.9228	24.1102
050301	26.0355	22.5201	21.1403	23.0323
050302	29.2007	*	*	29.2007
050305	32.7082	34.5185	36.7908	34.7340
050307	27.9830	17.2147	*	21.7503
050308	28.4019	29.3803	28.9284	28.9113
050309	24.4034	23.7884	25.3515	24.5133
050310	20.6181	*	*	20.6181
050312	23.7936	26.7617	26.0015	25.5439
050313	23.1009	21.7577	25.6827	23.5594
050315	21.9227	24.7086	22.7359	23.0264
050317	19.4479	21.6937	*	20.5789
050320	30.6054	30.4101	32.4809	31.1252
050324	26.2735	26.6049	25.3694	26.0738
050325	23.2355	24.4862	23.6327	23.7872
050327	22.8511	23.9484	25.6450	24.1469
050328	23.1889	*	*	23.1889
050329	21.4125	19.7455	21.6984	20.9322
050331	25.5252	22.2536	25.0230	24.1261
050333	20.1468	19.4589	19.1449	19.5671
050334	32.0169	34.2330	34.2557	33.5307
050335	20.2013	23.0258	22.9926	22.0827
050336	20.0980	20.7979	21.3402	20.7523
050342	19.3524	20.1841	20.8255	20.1210
050343	17.3394	17.2085	*	17.2799
050348	20.7505	23.8779	25.1085	23.3219
050349	15.0515	14.9754	15.0667	15.0310
050350	25.0676	24.8340	26.4161	25.4163
050351	24.6936	25.4791	24.8121	24.9948
050352	23.5927	26.1380	26.4262	25.4187
050353	23.2468	23.0564	23.2699	23.1944
050355	17.1597	17.2778	21.0969	18.0157
050357	23.6411	22.6545	24.5345	23.6386
050359	20.4005	17.7907	21.7548	19.8316
050360	31.7608	31.3526	31.7583	31.6236
050366	21.3442	23.7528	19.6823	21.4770
050367	29.4763	28.2805	30.7328	29.5063
050369	24.2604	27.0548	26.2234	25.8174
050373	26.6548	26.9776	27.8275	27.1333
050376	25.3036	26.5840	28.0990	26.5882
050377	25.6401	17.1764	17.0012	20.1035
050378	22.2363	25.9810	26.9101	24.8709
050379	15.4994	15.2022	18.4278	16.2767
050380	30.5790	31.4343	31.9578	31.3600
050382	26.1465	26.1398	25.9244	26.0725
050385	25.9188	24.6083	*	25.2398
050388	13.7863	19.1512	22.0122	17.5709
050390	22.5668	25.0426	24.2700	23.9349
050391	22.4881	18.9266	20.0615	20.3952

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050392	21.9324	21.6729	22.9430	22.1487
050393	23.1387	25.6964	24.1981	24.3082
050394	22.2424	23.0604	23.1526	22.8333
050396	23.6322	24.0636	25.3729	24.3512
050397	20.7698	20.2601	20.6397	20.5453
050401	17.7807	20.7473	18.4593	18.9557
050404	19.2754	17.3396	15.9839	17.4356
050406	16.8931	17.3016	17.8596	17.3407
050407	30.1222	29.9642	30.8346	30.2996
050410	16.4735	17.6769	19.8508	17.8663
050411	32.2364	34.8899	33.1943	33.4145
050414	24.4243	24.2060	25.9723	24.9224
050417	21.8884	21.5739	23.3005	22.2456
050419	23.1162	23.7584	23.4936	23.4646
050420	22.6819	22.3166	23.5438	22.8448
050423	23.3296	17.3771	21.3552	20.6272
050424	23.7788	22.8350	24.0727	23.5641
050425	33.6911	32.8364	35.3712	34.0224
050426	23.7082	25.2453	29.0120	25.8759
050427	20.0698	20.1674	16.4330	18.6499
050430	21.3428	23.8788	21.2275	22.2136
050432	21.4984	24.4133	24.5630	23.4427
050433	16.8035	17.4643	18.9021	17.7004
050434	15.6348	19.7591	*	17.6624
050435	32.9865	25.6676	23.3426	26.8858
050436	16.3594	14.8121	*	15.5729
050438	24.0828	25.0138	23.2583	24.1266
050440	21.1100	23.5167	22.5400	22.3553
050441	28.7067	28.9804	31.8774	29.8169
050443	16.4308	19.9020	17.2875	17.7906
050444	24.6741	21.4533	22.4530	22.8550
050446	20.5383	20.4908	22.3422	21.1378
050447	18.4183	17.9751	18.9851	18.4558
050448	20.0757	19.7046	21.7718	20.5035
050449	22.1784	23.8001	23.4614	23.1469
050454	28.6857	28.7432	30.0792	29.2410
050455	19.9209	20.1643	19.8577	19.9840
050456	17.6229	20.1254	18.1585	18.5890
050457	31.2489	34.4949	32.1910	32.6376
050459	37.0914	*	*	37.0914
050464	22.3142	25.3292	25.7710	24.4665
050468	23.1701	23.3050	22.2926	22.8998
050469	23.4404	23.8759	24.5205	23.8915
050470	17.0353	16.0292	16.0805	16.3264
050471	24.2887	25.6172	27.1597	25.6415
050476	23.1428	22.4754	24.0253	23.2552
050477	27.7855	27.9595	27.5819	27.7866
050478	23.0530	24.5401	26.3306	24.6133
050481	26.8293	28.9722	27.7973	27.8692
050482	16.9268	18.1217	16.0114	17.0134
050483	21.6038	22.7182	*	22.1632
050485	23.1933	24.1983	24.6906	24.0174
050486	24.4967	*	*	24.4967
050488	32.8620	34.6939	31.7481	33.0979
050491	25.1011	26.8703	27.4600	26.4606
050492	21.4156	19.5457	20.5030	20.4277
050494	25.4078	29.2621	29.1296	27.9125
050496	33.0168	32.5168	34.9704	33.4862
050497	*	13.8110	15.4115	14.5264
050498	24.8445	24.9677	26.1716	25.3085
050502	22.6253	22.3788	25.3701	23.4214
050503	23.5911	24.4069	23.3745	23.7879
050506	21.2165	25.0845	25.0333	23.8164

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050510	33.4617	33.3774	33.7481	33.5309
050512	34.3138	35.3581	34.4368	34.6837
050515	35.0412	35.3419	33.7321	34.6571
050516	25.1850	24.7992	26.1969	25.4171
050517	20.3733	20.9550	22.0985	21.1081
050522	31.7326	35.3784	36.2127	34.2256
050523	28.4235	27.0544	31.2522	28.8864
050526	26.9206	23.8099	26.4014	25.6096
050528	18.6898	19.0611	18.9155	18.8867
050531	20.7332	22.7308	21.3948	21.6689
050534	23.3026	24.0700	24.0001	23.7954
050535	24.2257	25.4215	26.8511	25.4120
050537	22.2073	22.2256	24.0354	22.8159
050539	23.2501	20.7129	23.3846	22.4405
050541	34.6195	34.4573	36.6149	35.2691
050542	17.8537	16.0892	17.7737	17.2018
050543	23.0437	22.3994	21.6795	22.3610
050545	27.5713	26.3304	31.7280	27.9472
050546	27.7557	26.1949	38.8087	28.7303
050547	27.0845	26.8305	37.7681	28.7499
050548	26.5922	28.8083	29.8516	28.2370
050549	27.9098	27.2765	28.9615	28.0769
050550	25.7546	24.8048	25.6588	25.4034
050551	24.0488	25.4652	24.8084	24.7966
050552	22.8731	21.5216	20.3239	21.6775
050557	22.1385	21.1243	22.2562	21.8314
050559	24.6689	23.5759	24.7866	24.3485
050561	33.9268	34.5791	33.4423	33.9701
050564	24.5099	23.5922	24.2091	24.0891
050565	22.8785	23.7829	20.8349	22.3644
050566	18.3297	17.4423	22.3448	19.2949
050567	24.2349	24.6454	25.0787	24.6746
050568	20.5205	19.5816	20.5376	20.2025
050569	24.9453	26.5479	27.3429	26.2484
050570	24.4961	25.2294	25.8619	25.1838
050571	24.3741	26.2039	24.0154	24.8290
050573	25.1398	24.9644	25.6589	25.2612
050575	*	19.5611	20.7090	20.0979
050577	20.5177	25.1549	23.5487	22.9797
050578	28.9073	28.5379	28.9009	28.7846
050579	30.0694	30.4952	29.9348	30.1803
050580	23.9183	25.9004	24.6962	24.8350
050581	23.5660	23.8584	24.9807	24.1454
050583	23.3609	24.3987	25.8800	24.5448
050584	23.1610	21.2366	19.5805	21.2667
050585	26.4985	25.9426	24.2824	25.5872
050586	23.8402	23.4079	23.1850	23.4570
050588	30.3873	25.3094	24.5472	26.4705
050589	24.3453	24.8698	23.8880	24.3389
050590	*	22.4480	24.4797	23.4541
050591	22.3224	23.9412	25.0209	23.7207
050592	26.0528	21.1745	22.1174	23.0414
050594	22.7826	27.1584	27.7002	25.6455
050597	23.1789	22.8523	23.3280	23.1176
050598	28.1062	24.3597	23.9202	25.2869
050599	26.3191	29.1221	26.0892	27.1846
050601	32.8704	31.8670	29.7417	31.4201
050603	22.7500	23.3390	21.7031	22.5608
050604	33.3239	34.0461	35.4034	34.3023
050607	24.1052	*	*	24.1052
050608	16.1529	18.0947	18.1664	17.4208
050609	31.9340	34.9935	33.5028	33.4973
050613	23.4779	23.3835	30.2413	25.4419

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
050615	23.7015	23.8815	27.5682	24.9089
050616	22.7960	22.7437	24.9843	23.5101
050618	21.7032	21.6509	21.4895	21.6219
050623	30.3208	29.1806	27.5832	29.0384
050624	22.3419	22.7148	26.4659	23.7251
050625	24.3503	26.4849	27.5816	26.1377
050630	24.0961	23.9159	24.2120	24.0782
050633	21.9790	23.1918	25.4283	23.5401
050635	37.8481	*	*	37.8481
050636	20.8349	21.2618	23.5257	21.8335
050638	23.6341	18.2859	18.2159	19.5807
050641	21.3605	21.8315	17.1258	19.7042
050644	23.1229	22.3456	22.1489	22.5048
050661	20.4769	19.6780	*	20.1699
050662	28.2910	26.9606	35.0989	28.9225
050663	23.7097	30.6591	24.9110	25.8492
050667	24.1064	24.9979	27.5045	25.1663
050668	39.9001	42.0974	61.7751	44.9671
050670	21.8750	20.0152	24.6101	21.9523
050674	36.2361	34.7380	32.4807	34.3308
050675	15.8423	15.6794	*	15.7602
050676	17.5302	18.6672	20.2087	18.7455
050677	33.7056	35.6503	33.6070	34.3198
050678	22.6591	26.8741	22.7756	23.9129
050680	27.3188	28.0584	31.4839	28.9200
050682	17.9715	26.2882	17.3566	19.6443
050684	21.8067	22.3398	23.3697	22.4849
050685	32.1330	31.1725	35.1307	32.7762
050686	33.2515	35.2631	33.4420	33.9679
050688	29.9990	30.6635	31.0648	30.5922
050689	34.1851	30.7295	30.9399	31.8127
050690	33.8277	32.8204	34.8112	33.8469
050693	33.2977	26.8265	25.5662	28.3155
050694	22.5719	23.2293	23.5572	23.1120
050695	23.5215	21.1377	24.4301	23.0784
050696	26.4103	28.0015	28.3291	27.6235
050697	21.4716	21.1566	18.2338	20.1433
050699	28.4754	25.7843	17.5296	23.1610
050700	28.4522	*	*	28.4522
050701	27.6190	22.6959	24.3055	24.7548
050702	12.2518	*	*	12.2518
050704	20.7568	22.8716	22.7618	22.3025
050707	27.5065	26.2732	27.8958	27.2979
050708	21.9149	22.7821	24.8647	23.2324
050709	19.4255	21.9598	19.4977	20.2535
050710	26.8095	26.9060	27.5828	27.1479
050713	15.3027	17.7259	16.8538	16.6077
050714	*	28.9314	30.1925	29.4900
050715	19.1151	*	*	19.1151
050717	*	25.9534	28.7973	27.3346
050718	*	17.6062	18.0940	17.8064
050719	*	25.5508	23.0833	23.8495
050720	*	*	25.8677	25.8677
060001	20.5908	21.3659	21.1819	21.0411
060003	19.3243	19.8023	20.4682	19.8685
060004	21.7899	22.8750	21.4496	22.0469
060006	17.8613	19.3651	20.0213	19.0568
060007	16.3833	17.4682	18.2977	17.3945
060008	17.0944	18.0333	18.4590	17.8646
060009	21.1795	21.4312	22.7164	21.8027
060010	22.7241	24.0872	23.6827	23.5135
060011	21.9727	23.4366	22.3458	22.5831
060012	19.7746	20.1442	19.4932	19.7974

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
060013	19.1369	22.7346	19.1256	20.3432
060014	20.5353	24.2459	24.3210	23.0067
060015	23.5675	20.9773	23.2469	22.5866
060016	15.9627	16.4707	20.2408	17.3661
060018	21.8607	20.3183	21.5083	21.2146
060020	17.7250	18.3099	18.8985	18.3187
060022	19.6488	21.0558	21.0830	20.6200
060023	19.6534	19.2373	21.5475	20.1296
060024	22.8347	21.9955	22.9185	22.5887
060027	21.6731	20.9846	22.0713	21.5836
060028	22.2461	23.2065	23.1792	22.8860
060029	21.4111	20.8585	18.2938	20.0752
060030	20.0345	20.5002	20.3452	20.2923
060031	19.3998	21.1649	22.5067	20.9951
060032	22.3702	23.4162	22.8123	22.8765
060033	13.8165	15.9085	16.0760	15.2591
060034	21.4110	22.4791	23.2816	22.4305
060036	19.2386	15.0698	18.5988	17.4095
060037	14.0458	15.5611	15.4513	15.0213
060038	14.3084	14.0791	14.3249	14.2429
060041	14.8299	14.8934	19.1263	15.9980
060042	20.0815	19.1892	20.8597	19.9134
060043	13.0544	13.6717	13.4443	13.3963
060044	22.5286	19.7039	20.8673	21.1240
060046	20.4359	19.4567	22.2699	20.7384
060047	15.1181	15.8770	17.1534	15.9786
060049	20.6427	21.7797	23.0613	21.7878
060050	16.8012	18.2238	19.0832	18.0606
060052	12.5517	13.4210	14.8729	13.6675
060053	14.9399	15.9806	18.0232	16.2596
060054	19.3943	22.8985	20.4160	20.8278
060056	17.0509	18.2831	18.1263	17.9597
060057	23.3804	26.4046	25.4185	25.1123
060058	16.9064	15.4856	13.8539	15.6088
060060	14.8894	15.6469	15.6018	15.4330
060062	14.9354	17.2991	16.8640	16.3901
060063	15.0896	*	*	15.0896
060064	20.9349	21.2207	22.7797	21.6636
060065	24.3032	21.6305	24.5572	23.4210
060066	14.0672	16.3485	17.2537	15.7129
060068	19.6355	*	*	19.6355
060070	16.5821	17.3184	18.8960	17.6173
060071	16.9545	17.5987	17.4068	17.3254
060073	15.8385	15.7860	17.0846	16.2338
060075	22.8498	24.1550	23.8724	23.6295
060076	19.2861	24.8732	20.3265	21.3796
060085	13.4761	13.6277	14.3409	13.7955
060087	21.0277	*	*	21.0277
060088	16.6753	25.2786	13.7174	17.2655
060090	14.5096	22.2974	16.3760	17.6196
060096	23.1232	21.9623	20.8937	21.9261
060100	21.9983	23.5986	23.9305	23.4279
060103	22.3414	24.8151	23.5083	23.4950
060104	22.3008	22.2295	21.1820	21.8472
060107	13.6449	14.2698	21.9221	15.1674
070001	26.5150	26.0878	26.3596	26.3266
070002	25.4570	26.2801	26.1768	25.9680
070003	26.0894	25.6949	27.5200	26.4175
070004	23.2664	22.4871	24.2567	23.3158
070005	25.5739	26.6483	26.9151	26.3676
070006	28.7139	27.5674	28.6413	28.3103
070007	27.1867	26.9505	26.3313	26.8152
070008	26.0269	23.0227	24.2971	24.3585

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
070009	23.4686	24.6201	24.1871	24.0886
070010	25.9375	26.2354	29.2194	27.0543
070011	23.9603	23.3638	23.0883	23.4486
070012	25.1022	23.0321	28.8067	25.3536
070015	25.3317	23.8240	28.1204	25.7263
070016	26.3005	24.9148	24.4633	25.2035
070017	24.8038	26.2923	26.0424	25.7039
070018	28.8776	28.0689	30.6864	29.1923
070019	24.7025	25.7283	24.9249	25.1145
070020	23.7227	23.9987	25.9964	24.5532
070021	26.5173	25.2978	26.3043	26.0246
070022	25.0845	26.5691	26.9111	26.1557
070024	25.1491	25.2983	24.8948	25.1081
070025	25.4055	25.1315	25.4345	25.3241
070026	18.7892	*	*	18.7892
070027	23.6381	23.6412	26.8450	24.6648
070028	24.6913	24.6788	25.7492	25.0300
070029	22.7507	22.0080	23.9682	22.8885
070030	24.9676	28.9117	22.1578	25.5338
070031	21.6565	23.4419	24.1198	23.0342
070033	28.8099	30.4214	31.4736	30.2068
070034	29.1220	28.9200	29.4916	29.1706
070035	23.0574	23.0869	24.1423	23.4347
070036	28.9463	28.8400	29.9470	29.2263
070039	21.7791	22.9032	22.3356	22.3067
080001	25.2849	25.4836	24.8833	25.2209
080002	15.5984	19.6011	20.1965	18.4286
080003	22.3957	22.1856	23.1275	22.5300
080004	19.7725	21.9391	22.9706	21.5842
080005	14.4289	*	*	14.4289
080006	22.2632	20.0792	22.6671	21.6173
080007	20.3833	19.6213	21.3746	20.4985
090001	25.8921	21.7526	21.5751	23.1400
090002	19.6997	19.4191	21.5726	20.1912
090003	28.6092	22.1090	23.1268	24.5792
090004	24.4267	24.3367	25.5054	24.7042
090005	24.8766	23.8620	26.3074	24.9846
090006	20.0816	20.8675	22.0957	21.0167
090007	21.6551	22.1973	29.2840	24.7855
090008	21.5972	20.2166	25.2708	22.3042
090010	15.8676	24.1287	23.6616	20.2595
090011	27.3741	27.4781	26.6349	27.1495
100001	17.6948	19.5796	20.2157	19.1458
100002	21.3243	20.7136	21.0222	21.0141
100004	15.2465	14.6283	15.4149	15.0845
100006	20.6302	20.1133	21.2293	20.6802
100007	21.7217	21.7242	22.1590	21.8790
100008	20.7232	20.4980	20.8381	20.6876
100009	24.2947	22.6419	22.1741	22.9648
100010	21.9101	21.9078	23.0637	22.2904
100012	18.5169	19.6177	20.4659	19.5030
100014	19.8352	19.8023	19.5770	19.7276
100015	18.2394	18.4779	18.0654	18.2696
100017	17.7739	19.0608	19.8655	18.9086
100018	20.8392	21.0332	21.6388	21.1816
100019	19.8134	22.6152	23.5462	21.9719
100020	26.1783	21.3848	20.7816	22.5004
100022	25.8853	26.4094	26.5695	26.2778
100023	21.1068	19.9739	19.1787	20.0604
100024	20.7760	21.8791	22.1332	21.6047
100025	19.1219	18.7774	19.4529	19.1169
100026	20.7591	20.5641	20.9461	20.7639
100027	12.9410	19.1481	14.7916	15.3484

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
100028	19.7491	19.3757	19.3371	19.4791
100029	19.1768	20.8745	20.8950	20.2753
100030	18.8229	22.8204	20.5952	20.6758
100032	19.3165	19.8127	19.7451	19.6185
100034	18.2314	17.8743	19.5282	18.5138
100035	19.5842	20.1540	23.8117	21.2289
100038	24.7851	23.3578	24.5864	24.2183
100039	20.2529	21.5297	21.7861	21.1854
100040	18.6417	19.0449	18.6321	18.7662
100043	17.5215	18.7993	18.8206	18.3605
100044	21.1370	21.4764	22.7236	21.7975
100045	20.7688	20.9216	21.0228	20.9056
100046	21.2094	21.6207	21.3028	21.3728
100047	18.8677	20.0114	20.6068	19.8263
100048	13.5021	15.0584	15.7790	14.8232
100049	18.5598	18.8535	19.1025	18.8421
100050	16.6058	17.2377	17.9039	17.2452
100051	18.8377	23.1273	17.9453	19.6449
100052	16.1855	17.9537	18.1780	17.4312
100053	18.7103	20.1724	19.6800	19.5213
100054	18.1853	23.5491	21.1518	20.9367
100055	17.6226	18.0547	18.8760	18.1971
100056	23.6545	25.7863	21.8506	23.8349
100057	18.7489	19.9712	19.5319	19.4242
100060	22.3904	23.2561	23.5997	23.0802
100061	21.7923	22.1133	22.9176	22.2483
100062	17.9575	19.4370	21.4424	19.6570
100063	16.2324	19.2629	18.4642	17.9066
100067	17.3950	18.0877	18.4851	17.9682
100068	18.6480	19.9305	19.8308	19.4718
100069	16.1393	16.8271	17.3666	16.7757
100070	20.3358	18.7408	20.0381	19.6563
100071	16.4756	17.5451	17.7234	17.2640
100072	19.2223	21.0225	20.5968	20.3580
100073	18.1554	21.1898	22.2812	20.4948
100075	18.0548	18.3688	19.4480	18.6211
100076	16.2469	17.8733	17.8612	17.3644
100077	19.6214	22.3438	19.0640	20.3179
100078	18.2791	18.4499	19.2891	18.6609
100080	21.1603	22.1966	22.7153	22.0462
100081	13.9564	14.8313	15.4253	14.7661
100082	19.8033	18.8998	*	19.3432
100084	20.4002	22.3674	22.7009	21.8810
100085	21.0802	22.1231	*	21.5986
100086	21.1625	21.6997	23.3718	22.0734
100087	23.1162	23.6090	23.6562	23.4609
100088	20.0571	20.3693	20.5566	20.3435
100090	17.8768	19.1479	19.7695	18.9939
100092	18.1953	17.9216	20.1760	18.7907
100093	16.6310	16.5128	16.8422	16.6633
100098	19.0319	19.2427	20.8315	19.7124
100099	15.2983	15.7823	15.7591	15.6112
100102	19.3330	18.9701	19.7673	19.3542
100103	18.1019	17.2364	18.7844	18.0201
100105	21.5028	21.6604	21.8268	21.6611
100106	19.3113	17.2527	17.4958	17.9164
100107	18.0142	20.1281	20.0719	19.4041
100108	11.4692	19.9593	20.1125	16.4375
100109	22.1715	20.8440	20.8370	21.2360
100110	19.6439	20.8995	20.1853	20.2509
100112	9.7706	25.2570	15.2128	15.6728
100113	22.2584	23.2020	21.3489	22.1642
100114	23.4501	21.6262	22.8178	22.5825

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
100117	18.8619	20.7624	20.6962	20.1889
100118	19.7608	22.8702	20.7323	21.1427
100121	19.3435	*	18.5842	18.9363
100122	18.0551	19.8783	19.2643	19.0686
100124	19.0527	17.0713	20.4022	18.8192
100125	17.3358	18.9535	19.6097	18.6719
100126	18.0943	19.5413	19.3103	18.9490
100127	19.8727	19.9860	19.2122	19.6859
100128	21.3653	20.1536	22.8826	21.4045
100129	18.5723	19.1936	*	18.8646
100130	19.1052	18.6751	20.0947	19.3019
100131	22.1680	23.4373	23.1622	22.9338
100132	16.8978	18.1167	18.7863	17.9218
100134	13.4711	15.1764	15.9733	14.8260
100135	17.4785	18.8253	19.1865	18.5050
100137	19.0464	18.6955	19.5562	19.1372
100138	11.0135	17.1373	14.9539	13.7935
100139	15.6444	15.6514	15.2532	15.5227
100140	17.3518	17.1389	19.0584	17.8826
100142	18.6812	19.6815	18.4113	18.9199
100144	15.0197	12.2877	*	13.4059
100145	19.1143	*	*	19.1143
100146	17.8692	18.1267	21.3359	19.1001
100147	14.6751	14.6616	15.2348	14.8665
100150	21.0224	21.2807	21.5057	21.2659
100151	19.3990	21.6087	23.8489	21.6478
100154	19.8485	20.0015	20.4068	20.1020
100156	17.1335	19.4980	18.4779	18.3856
100157	21.0324	22.6744	22.6195	22.1032
100159	16.3778	10.2793	10.7818	11.9429
100160	21.6339	20.5581	23.3121	21.8278
100161	21.5025	22.2994	22.3053	22.0508
100162	19.8748	20.1411	20.3110	20.1117
100165	18.5739	19.0388	22.6622	20.3299
100166	20.4228	20.0250	21.2309	20.5491
100167	21.8138	23.4075	23.2969	22.8605
100168	20.1260	20.1994	20.3167	20.2165
100169	20.7778	20.9506	20.3017	20.6703
100170	15.1167	18.5088	19.3005	17.5325
100172	15.1848	14.3446	14.8826	14.8099
100173	17.3416	18.5662	17.1337	17.6572
100174	20.5125	26.1826	21.9807	22.2819
100175	17.8237	18.1692	20.5442	19.0035
100176	24.6978	22.8604	24.3089	23.9493
100177	22.0034	24.4296	24.4284	23.5639
100179	20.9053	22.3015	23.0849	22.0467
100180	18.4754	20.2130	21.5388	20.0049
100181	24.5704	23.0800	18.9510	21.8206
100183	20.8579	24.6121	23.0654	22.6623
100187	20.6938	20.2533	20.8535	20.6013
100189	21.0102	21.3147	26.5962	23.0255
100191	18.4692	19.9879	21.0647	19.7731
100199	23.3713	21.7193	*	22.5030
100200	22.2575	22.4579	23.8729	22.8861
100203	18.8628	*	*	18.8628
100204	20.2049	20.8995	20.2193	20.4418
100206	20.3511	19.5710	20.1171	20.0138
100207	15.9173	*	*	15.9173
100208	20.8337	21.2117	20.7029	20.9220
100209	19.7329	22.4577	23.3903	21.8570
100210	19.1799	21.3575	21.8545	20.7662
100211	25.5277	20.6427	20.7516	21.9172
100212	25.3441	21.1187	21.1263	22.2176

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
100213	19.1238	20.6558	21.1818	20.2975
100217	19.8700	20.5909	22.7335	21.0211
100220	19.9121	21.2796	21.8246	20.9627
100221	22.2517	17.3965	21.2321	20.0812
100222	22.1958	*	*	22.1958
100223	18.7580	20.6302	20.2233	19.8755
100224	24.7023	20.0251	21.8628	21.8826
100225	20.6404	20.6802	21.5059	20.9335
100226	24.8641	20.6858	21.8808	22.2342
100228	23.6986	21.3168	20.8810	21.8300
100229	18.2070	19.6908	18.2350	18.7682
100230	20.6018	20.5051	22.5650	21.2357
100231	17.4002	17.9226	18.7526	18.0268
100232	17.3171	19.3491	19.8002	18.8267
100234	21.5763	20.9104	21.6360	21.3290
100235	17.6648	17.1622	*	17.4262
100236	21.8111	20.3766	20.6942	20.8937
100237	22.9344	22.0865	23.2408	22.7368
100238	17.6310	19.6367	20.8252	19.4032
100239	19.7605	21.3193	19.4481	20.1474
100240	17.9339	20.4340	21.0606	19.8014
100241	13.8344	14.7224	17.1063	15.0865
100242	17.1154	17.9260	18.6938	17.9097
100243	20.3838	21.2644	20.8041	20.8228
100244	17.4124	18.6227	20.5352	18.9148
100246	21.2160	19.6376	21.9247	20.8876
100248	21.5399	20.7007	21.2988	21.1681
100249	19.0243	19.2808	18.1397	18.8067
100252	17.8726	17.7778	19.8079	18.4729
100253	20.6014	21.3232	22.4778	21.5023
100254	20.9080	19.6598	19.5523	19.9896
100255	21.0224	25.2119	21.0284	22.2338
100256	23.5640	20.9356	21.2786	21.7690
100258	21.8764	21.3501	20.0300	21.0257
100259	19.8600	20.3815	21.1160	20.4723
100260	21.2224	21.0506	24.9183	22.3504
100262	19.5874	20.0433	21.0927	20.2558
100263	16.9012	*	*	16.9012
100264	17.6085	19.1556	19.9491	18.8967
100265	19.8571	18.8301	18.2291	18.8491
100266	17.7319	18.2993	19.3623	18.4763
100267	17.0986	20.1141	21.7430	19.6266
100268	23.5863	23.9249	24.0538	23.8633
100269	21.2047	21.6724	22.5114	21.8200
100270	19.8576	15.1462	16.7148	17.2012
100271	19.9208	20.4824	20.8695	20.4494
100275	21.3273	20.9188	21.4904	21.2374
100276	21.9797	22.3646	24.1022	22.8308
100277	16.1410	16.6255	19.7241	17.0041
100279	23.0213	22.9095	22.5879	22.8402
100280	16.5851	17.3676	18.1972	17.4129
100281	22.0202	22.4392	23.0142	22.5262
100282	19.7717	19.1978	18.4884	19.1653
100284	*	*	18.9448	18.9448
110001	18.0571	19.1971	20.1150	19.1086
110002	17.3674	17.1406	19.5158	18.0122
110003	16.9099	18.1168	17.1450	17.3940
110004	18.9468	19.5591	19.7733	19.4194
110005	19.2639	17.7348	22.4568	20.0888
110006	20.1273	20.7820	21.0601	20.6571
110007	23.4976	21.9505	25.2523	23.5682
110008	18.2642	22.0081	18.5265	19.5622
110009	14.8218	16.3069	17.4306	16.2843

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
110010	24.5493	23.3213	23.9104	23.9180
110011	18.2846	18.6144	18.9823	18.6368
110013	16.0264	16.2811	18.9160	17.1183
110014	16.1168	16.0658	18.1787	16.7192
110015	19.4769	21.2146	20.9926	20.5614
110016	15.2967	22.5321	14.2398	16.6540
110017	10.5399	13.1960	22.2537	15.3899
110018	21.0415	19.6064	22.1480	20.9298
110020	18.5251	18.3147	19.4617	18.7736
110023	18.6460	21.1994	22.0546	20.5885
110024	19.7923	20.7297	20.7345	20.4144
110025	18.6463	19.5749	20.4232	19.5033
110026	16.1414	17.2977	16.2484	16.5517
110027	14.6834	16.0642	14.7081	15.1696
110028	19.8894	20.1547	29.1670	22.3800
110029	20.0507	20.2906	21.2150	20.5454
110030	17.6785	18.8105	19.6412	18.7203
110031	21.5794	19.9482	20.0553	20.4598
110032	16.1859	15.7349	18.2014	16.6413
110033	21.4143	22.1879	25.6335	22.9577
110034	18.1882	19.6055	19.5554	19.0987
110035	21.1670	19.3795	22.7950	21.1658
110036	24.4181	22.2498	20.7284	22.3301
110038	16.3750	17.7060	17.7396	17.2680
110039	20.7710	20.6011	20.4998	20.6248
110040	16.4043	17.0743	16.8083	16.7529
110041	16.6927	18.8035	20.2755	18.6583
110042	20.6503	24.0153	25.2331	23.2575
110043	17.2175	20.1016	20.6150	19.2219
110044	19.5983	16.3624	17.2087	17.5794
110045	19.9445	20.2498	21.3049	20.4714
110046	19.2327	19.7377	21.4905	20.1167
110048	15.6463	16.3148	15.6113	15.8483
110049	14.2135	16.1817	16.8639	15.7669
110050	18.7516	20.7619	19.2291	19.5578
110051	15.7475	17.0070	17.2292	16.6496
110052	15.0562	*	*	15.0562
110054	19.2712	*	20.0549	19.6625
110056	16.4960	15.6202	17.7959	16.7305
110059	17.6984	16.6678	16.7990	17.0253
110061	13.7196	15.0367	16.3557	15.0889
110062	12.2107	18.8019	17.0053	16.1264
110063	17.9743	16.9612	18.5071	17.7965
110064	18.3368	18.9515	19.1203	18.8163
110065	13.3245	15.6771	16.3546	15.1604
110066	20.6502	21.0207	22.4189	21.3274
110069	18.3519	19.3109	20.9575	19.5384
110070	18.2264	21.0227	17.3438	18.7743
110071	14.8902	14.5984	18.8321	15.8863
110072	12.4303	12.7877	12.7625	12.6652
110073	15.1377	15.4261	16.4658	15.6663
110074	20.7572	21.3945	22.3769	21.5169
110075	17.0067	18.5199	20.1757	18.5793
110076	20.4430	21.2867	21.9798	21.2384
110078	24.7069	22.3718	24.0893	23.6954
110079	20.1385	21.0593	22.1070	21.0913
110080	23.4336	18.4768	19.1839	20.1449
110082	22.0078	23.8768	24.3140	23.4175
110083	21.3578	23.1219	23.1463	22.5746
110086	14.9756	18.2815	16.6374	16.5417
110087	20.5420	21.7773	22.7069	21.7189
110089	18.5761	18.5587	19.3855	18.8318
110091	21.3789	19.5114	21.5328	20.7784

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
110092	15.0890	17.3479	16.9725	16.4433
110093	14.8049	*	16.9827	15.7486
110094	13.8658	14.5641	16.9503	15.0650
110095	15.9478	16.4670	17.1195	16.5075
110096	16.3202	16.8541	17.4157	16.8647
110097	15.6164	15.5811	17.4558	16.1121
110098	14.0067	16.3532	16.0597	15.3226
110100	20.3764	18.6978	19.0764	19.3213
110101	11.7278	10.8187	18.8491	12.7872
110103	11.9352	13.6842	21.1837	14.0859
110104	15.3184	15.7781	15.9431	15.6829
110105	16.5196	16.8909	16.7775	16.7306
110107	17.3921	19.3609	19.3897	18.7335
110108	15.1401	19.7938	25.2161	19.3940
110109	16.3703	15.9359	16.4031	16.2270
110111	17.3215	18.5108	18.3951	18.0800
110112	19.1288	19.0619	19.8986	19.3117
110113	15.1896	16.8179	15.9532	15.9721
110114	15.1303	14.6888	16.4812	15.4358
110115	24.8332	43.9427	22.5049	27.8401
110118	15.3992	20.5368	19.7509	18.5122
110120	15.1878	15.2589	17.7452	15.9897
110121	15.5792	16.2711	19.3643	17.0685
110122	18.8497	21.1385	21.1469	20.3688
110124	17.1306	17.5732	18.3366	17.6460
110125	17.3254	19.1311	18.0090	18.1411
110127	13.7612	14.6143	20.3765	16.2641
110128	18.9705	18.1845	18.0835	18.4293
110129	18.1208	18.9388	19.0001	18.6851
110130	13.0779	16.0580	14.6011	14.6559
110132	15.0231	16.0419	16.3943	15.8158
110134	11.5583	12.5723	19.8639	15.1252
110135	17.0834	17.4380	17.3504	17.2967
110136	16.1680	18.0639	16.9629	16.8702
110140	17.8806	17.8870	17.7915	17.8571
110141	12.5051	13.2501	14.4935	13.4024
110142	12.3029	14.6144	13.9525	13.5947
110143	21.6898	20.1603	22.5926	21.5352
110144	17.9766	16.8685	17.5112	17.4397
110146	17.6068	16.1316	17.1835	16.9320
110149	22.2256	17.7535	32.1975	23.0615
110150	18.7724	20.2644	21.2909	20.0962
110152	14.7674	15.3996	15.1324	15.1011
110153	18.6862	19.2744	20.5068	19.4781
110154	14.8067	14.9636	17.3761	15.6408
110155	17.1370	15.5306	16.5146	16.3434
110156	15.3422	14.7477	16.3876	15.4698
110161	20.8657	21.7153	22.2861	21.6563
110163	18.2016	20.4202	18.6637	19.0060
110164	19.4946	20.2074	21.2160	20.2947
110165	18.9974	21.2577	20.8030	20.3401
110166	19.8510	20.5882	20.5049	20.3148
110168	19.8178	20.6646	21.8058	20.8014
110169	18.7189	20.6385	22.6648	20.4216
110171	20.0874	23.7893	25.5296	22.6284
110172	25.4390	23.3730	23.6803	24.1715
110174	14.2978	13.7339	14.6199	14.1905
110176	22.3971	*	*	22.3971
110177	19.5888	20.7187	21.2796	20.5272
110178	16.8555	18.8306	*	17.8083
110179	20.5161	22.7841	22.0767	21.7231
110181	13.7195	14.0941	12.9798	13.6399
110183	21.1797	23.3826	22.5148	22.3473

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
110184	20.9465	22.1970	22.1920	21.7791
110185	16.2487	16.7246	17.7925	16.9013
110186	17.3398	17.4287	18.3178	17.6984
110187	21.4462	20.1154	19.8419	20.4516
110188	20.0548	24.8376	23.7032	22.6465
110189	18.8627	22.2715	20.8786	20.7023
110190	19.4318	18.5728	18.3649	18.7761
110191	19.1065	20.2033	21.4033	20.2583
110192	20.7660	21.4951	21.0486	21.1064
110193	18.7807	20.6380	20.7867	20.0518
110194	15.0937	15.1480	14.8115	15.0165
110195	10.5227	13.9135	12.7261	12.3146
110198	26.1898	24.1999	24.8646	25.0493
110200	17.2129	18.1862	17.7744	17.7301
110201	19.2438	20.4699	20.9497	20.2248
110203	20.2958	26.8148	22.7453	23.1944
110204	20.5728	19.7317	30.7342	21.7754
110205	26.1154	21.1435	21.3617	22.7145
110207	12.8710	12.9727	14.7154	13.5335
110208	14.8907	15.1742	15.6161	5.1789
110209	20.4640	17.9190	18.6404	18.9942
110211	21.8226	20.9372	26.9151	23.1427
110212	12.6583	11.8545	14.3790	12.8830
110213	13.1976	14.3651	*	13.7453
110215	*	20.1928	18.1539	19.0047
110216	*	*	27.1878	27.1878
120001	26.7134	27.9213	29.0427	27.8237
120002	24.3780	25.0744	25.2021	24.8896
120003	23.8452	25.9059	23.9115	24.5394
120004	24.0456	23.9208	24.8632	24.2413
120005	20.5380	23.3975	24.1662	22.6197
120006	23.7151	25.0895	25.8943	24.8700
120007	23.2684	22.7200	22.8772	22.9509
120009	19.0216	17.4693	16.4485	17.5600
120010	25.3976	25.1480	24.1923	24.8868
120011	33.5459	35.0582	37.2759	35.3313
120012	22.5219	23.1144	21.8507	22.5391
120014	24.0467	22.8866	24.1208	23.6739
120015	29.0747	32.9906	42.6465	33.1800
120016	29.4104	27.9127	45.1899	31.1230
120018	25.6088	24.5031	31.1879	26.2841
120019	21.9199	22.9341	25.5659	23.4285
120021	19.4236	23.4508	23.1839	21.8865
120022	17.9306	21.7868	19.2614	19.5032
120024	22.2846	29.4808	32.2514	26.8486
120025	19.0197	20.1065	50.6376	21.3455
120026	23.2237	26.0787	25.1314	24.7719
120027	24.5549	24.7255	24.4535	24.5737
120028	23.4873	27.5023	27.0897	25.8902
130001	24.9511	18.8471	17.6306	20.1752
130002	16.1853	16.6620	16.9867	16.6200
130003	19.9499	21.7313	22.3430	21.3583
130005	20.1678	20.7169	21.2386	20.7149
130006	18.8705	19.3392	20.4614	19.5797
130007	19.8442	20.8338	21.8107	20.8426
130008	12.9177	12.5506	13.6018	12.9892
130009	18.2958	19.1837	15.9701	17.7296
130010	21.4325	17.6795	17.5119	18.7875
130011	19.0816	20.5031	20.1147	19.9190
130012	22.6153	22.9813	24.9976	23.5891
130013	19.2170	17.4038	15.1129	17.1523
130014	17.9836	18.9769	19.2107	18.7286
130015	15.2662	15.7233	18.5913	16.3849

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
130016	16.9987	17.3942	19.0516	17.7864
130017	16.8822	17.1710	19.6875	17.7220
130018	17.9651	19.7368	19.8425	19.2288
130019	17.2317	18.6648	19.1711	18.3322
130021	12.2562	12.8588	15.6155	13.6528
130022	19.5040	16.5270	18.9127	18.2241
130024	18.3789	19.3634	19.0703	18.9600
130025	15.2691	17.5213	16.4627	16.4881
130026	20.5535	21.5934	21.8106	21.3093
130027	20.7044	21.4279	20.5344	20.8883
130028	18.2074	19.1093	20.9674	19.4388
130029	20.3153	18.4263	18.7694	19.1364
130030	18.3981	17.8440	17.5759	17.9347
130031	17.6458	16.2397	16.7766	16.8967
130034	18.8164	16.9873	18.9483	18.2785
130035	20.4708	19.3478	20.7770	20.1943
130036	13.7942	13.7933	13.6362	13.7373
130037	17.7374	18.8071	18.6856	18.3986
130043	16.0686	16.5102	16.7904	16.4511
130044	13.1816	17.8160	13.4513	14.6424
130045	16.4655	16.0990	19.0208	17.0869
130048	15.0924	16.0899	16.7900	15.9311
130049	20.3928	20.3129	22.4440	21.0760
130054	17.7802	17.2729	17.7085	17.5766
130056	15.6551	14.6862	20.9476	16.5492
130058	17.7462	*	*	17.7462
130060	20.8508	21.8662	22.7399	21.8288
130061	16.7839	15.4006	14.7394	15.6929
130062	15.1086	16.5672	19.8157	17.1915
130063	*	15.9441	18.8024	17.8420
140001	15.4448	16.3372	17.7990	16.4814
140002	19.2575	19.0248	19.9284	19.3999
140003	18.0001	21.2886	17.8595	18.9466
140004	17.5200	15.7042	17.4574	16.8965
140005	10.8718	11.6127	12.3002	11.5858
140007	22.4015	22.9799	23.8585	23.0838
140008	21.2844	21.6548	22.1111	21.6838
140010	25.2227	31.8207	28.5635	28.3677
140011	17.2856	17.8676	18.6164	17.9499
140012	19.4406	23.0653	21.4374	21.2652
140013	17.3488	18.3060	19.6722	18.4213
140014	20.7563	22.4737	21.4042	21.5054
140015	15.0232	16.6735	17.6805	16.4314
140016	12.5363	13.1278	14.4938	13.3972
140018	21.4147	22.3070	22.4132	22.0345
140019	15.3435	16.6548	16.4254	16.1654
140024	14.6674	16.8271	15.3782	15.5912
140025	16.9489	16.9462	18.5135	17.4713
140026	15.9557	16.6612	18.3220	16.9446
140027	17.5023	18.7553	19.2149	18.5013
140029	21.0358	22.8322	26.0833	23.2140
140030	22.4414	21.9475	23.1760	22.5308
140031	15.9442	19.5731	17.6067	17.6942
140032	17.3363	18.1058	19.0383	18.1645
140033	22.5583	24.1722	25.1639	23.9291
140034	19.1482	19.5278	19.8792	19.5183
140035	12.9963	15.2649	15.5040	14.5633
140036	17.0419	18.5771	19.1076	18.2935
140037	12.5012	13.0764	14.1083	13.2105
140038	17.6094	18.3035	18.4948	18.1352
140040	16.2462	19.9267	16.7450	17.5895
140041	17.2829	17.6582	18.5952	17.8248
140042	15.6092	15.4095	15.8892	15.6354

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
140043	18.9464	19.4683	20.1176	19.5022
140045	20.6541	15.5807	17.7799	17.9528
140046	16.4621	18.9763	18.6371	18.0097
140047	16.3298	17.1539	13.3610	15.4382
140048	20.5773	24.0913	23.9545	22.8943
140049	21.5937	28.4958	26.9483	25.7338
140051	20.8455	23.8264	24.0796	22.8956
140052	19.6045	19.6409	17.9571	19.0338
140053	17.8218	19.1892	19.9620	18.9702
140054	26.1497	22.1921	23.1576	23.7695
140055	14.8031	16.3404	14.3603	15.1391
140058	17.2716	17.4927	18.6861	17.8100
140059	15.3934	15.0195	*	15.1978
140061	15.9612	17.3012	18.2039	17.1185
140062	27.0912	28.0877	28.5304	27.9131
140063	22.3882	25.3641	29.1453	25.1919
140064	19.2549	19.1023	18.9379	19.0960
140065	23.1610	24.1128	25.3336	24.1516
140066	16.1759	17.3902	13.6491	15.5770
140067	18.4031	19.3267	19.5292	19.0846
140068	18.8739	19.9691	21.6188	20.0995
140069	16.1453	16.7544	17.3879	16.7949
140070	19.2995	22.9678	22.7153	21.2244
140074	19.0077	19.3504	21.6052	19.9120
140075	22.5083	21.6313	21.6434	21.9439
140077	16.6447	17.5305	17.3647	17.1709
140079	21.9205	23.3020	23.6928	22.9153
140080	20.9999	21.0739	22.1968	21.3875
140081	15.5103	16.2247	16.9808	16.1897
140082	22.6227	23.8960	29.7262	24.9037
140083	18.1349	19.3145	21.0330	19.4951
140084	20.0133	20.9709	22.3467	21.0939
140086	17.3717	18.3803	19.1613	18.3356
140087	18.3639	16.1009	17.1147	17.1839
140088	24.2568	25.2369	25.4176	24.9650
140089	17.2086	17.6366	18.3157	17.7164
140090	23.5888	26.4325	26.9364	25.3709
140091	20.7039	20.9018	21.9322	21.1441
140093	19.1469	18.2899	20.1528	19.1437
140094	20.6129	21.4709	21.9383	21.3227
140095	21.5376	24.0549	24.2859	23.1400
140097	16.8997	17.5081	21.1719	18.4160
140100	19.0588	21.3581	23.1399	21.1571
140101	26.0894	21.5473	21.4211	22.7744
140102	15.0777	17.1500	17.5729	16.5644
140103	17.8586	19.2783	18.1303	18.4145
140105	20.9068	22.6573	22.8944	22.1275
140107	12.7573	13.7533	11.8383	12.6800
140108	28.6028	25.4742	26.9971	26.9964
140109	15.4724	15.7465	14.5498	15.2467
140110	18.8112	19.1822	19.2888	19.0728
140112	16.2399	17.6856	17.6974	17.1885
140113	17.9151	19.0592	19.5584	18.8265
140114	20.4808	21.1639	21.0976	20.9149
140115	20.0939	21.1926	21.0433	20.7564
140116	21.8290	23.1177	23.8993	22.9520
140117	19.6445	21.5671	21.4876	20.8750
140118	23.0797	23.5952	24.3260	23.6559
140119	26.5042	29.1419	27.9145	27.8197
140120	14.8375	18.0743	17.9716	16.8874
140121	9.5268	16.0397	16.6993	13.2257
140122	23.7473	24.6470	26.1270	24.8110
140124	26.9706	27.1906	27.9813	27.3549

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
140125	17.0974	17.6759	16.9516	17.2453
140127	19.4259	19.8973	20.0489	19.7765
140128	17.6751	19.4955	23.1327	20.0664
140129	15.2494	18.2639	20.2868	17.8627
140130	23.7682	22.2285	23.4298	23.1296
140132	23.0443	23.5475	23.3054	23.2992
140133	19.9083	21.4090	21.4166	20.8761
140135	17.6927	17.8100	17.3985	17.6268
140137	16.5141	16.8969	18.6330	17.3470
140138	14.5877	16.7420	17.1968	16.2121
140139	16.5794	14.0619	11.0397	13.5138
140140	15.2985	17.8243	17.6845	16.9747
140141	15.1782	17.5204	19.1097	17.2133
140143	18.7616	19.1862	19.0810	19.0186
140144	19.7913	21.3245	22.2864	21.1022
140145	16.6111	17.5471	18.1788	17.4556
140146	23.7400	21.9573	19.9704	21.7285
140147	24.8191	16.1336	18.8049	19.2135
140148	19.5026	18.6598	18.7730	18.9637
140150	27.8485	27.3378	24.7976	26.6536
140151	19.3016	21.3896	20.0310	20.2086
140152	22.4270	24.6333	25.6011	24.1041
140155	17.3131	19.9738	20.2778	19.1103
140158	22.2666	22.7639	22.7988	22.5990
140160	17.8822	17.7691	17.7921	17.8132
140161	19.0448	20.0948	20.3799	19.8258
140162	18.4167	19.6464	20.3452	19.4479
140164	18.6120	18.7806	18.6589	18.6860
140165	15.4186	14.9156	14.7223	15.0080
140166	17.5434	17.5496	18.3833	17.8149
140167	16.5671	17.1479	17.6525	17.1325
140168	16.4638	16.6770	17.7453	16.9752
140170	14.1360	16.1621	16.4107	15.5211
140171	14.7316	14.1637	15.0237	14.6354
140172	20.7982	23.8431	23.6262	22.5610
140173	18.4788	15.1487	16.3924	16.7054
140174	19.9216	20.5339	35.9320	23.2157
140176	21.4129	23.2866	24.5338	23.0397
140177	18.1692	18.2648	15.0827	17.1204
140179	22.6989	21.1948	21.9859	21.9622
140180	23.2536	22.4548	22.7996	22.8262
140181	20.5461	20.8709	21.9864	21.1001
140182	20.7013	22.0170	28.9515	23.2649
140184	14.9763	17.8155	17.2401	16.6194
140185	17.3616	17.6514	18.2867	17.7696
140186	18.9878	22.7890	23.5034	21.7241
140187	17.6910	17.9201	18.3331	17.9863
140188	14.8373	15.2479	16.1907	15.4001
140189	19.0791	21.0616	20.6627	20.2758
140190	15.8770	16.3366	17.5263	16.5534
140191	24.7368	25.8835	25.2628	25.2833
140193	15.5196	15.8022	17.4057	16.2409
140197	17.9828	18.6394	19.3774	18.6752
140199	18.8333	18.3507	18.0450	18.4044
140200	21.6508	21.5220	21.7680	21.6496
140202	22.1800	22.1939	23.7955	22.7597
140203	20.7854	19.9194	21.0848	20.5915
140205	17.2369	17.4751	20.0784	18.0505
140206	20.5096	21.3295	22.5109	21.4570
140207	20.2048	21.9779	22.3905	21.3996
140208	23.9441	25.9900	26.2527	25.3856
140209	17.7889	18.1206	20.1557	18.6405
140210	12.6648	15.6899	14.8248	14.4319

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
140211	20.9615	21.8891	22.6265	21.8594
140213	26.2041	27.0645	24.9892	26.0871
140215	14.4544	15.9949	15.2893	15.2456
140217	23.3192	24.8229	25.7329	24.5914
140218	15.0750	14.9459	14.9851	15.0038
140220	16.7341	17.6370	17.8450	17.4280
140223	21.4725	24.9249	24.9017	23.6377
140224	22.9945	25.8668	32.8292	26.7133
140228	18.6731	19.6988	20.1688	19.5400
140230	16.5979	18.0918	18.2983	17.6740
140231	21.6062	23.9176	24.5019	23.4404
140233	18.3703	19.4542	21.2333	19.6539
140234	18.7156	18.9945	*	18.8552
140236	13.1341	*	12.9253	13.0112
140239	18.8785	18.8127	20.3745	19.3689
140240	24.2141	23.6860	24.6949	24.1989
140242	22.6679	24.5428	25.2317	24.1792
140245	15.5554	13.4839	14.2481	14.3597
140246	12.8238	13.4639	11.6267	12.5798
140250	23.4127	25.0876	23.6449	24.0578
140251	20.5813	21.4385	21.9435	21.3153
140252	24.4856	25.2246	25.0220	24.9139
140253	16.7356	18.5511	19.5858	18.2440
140258	21.1321	23.2973	25.3622	23.2691
140271	15.3606	15.5079	12.0079	14.1590
140275	17.9597	20.1699	23.8171	20.5857
140276	23.7163	26.6777	25.3134	25.2323
140280	18.8420	20.2360	18.8300	19.2649
140281	23.3433	24.0192	25.2719	24.2302
140285	14.7087	18.1181	18.5916	17.2227
140286	19.9500	20.3735	26.1290	22.0885
140288	21.8213	25.2327	24.4331	23.7989
140289	16.4542	17.1388	18.1747	17.3055
140290	21.2384	21.1784	22.8590	21.7763
140291	22.4352	25.0911	24.9537	24.1790
140292	22.7136	20.8560	21.9950	21.8371
140294	17.5226	17.7226	17.7301	17.6645
140297	21.4692	*	*	21.4692
140300	23.2560	25.3662	27.8436	25.5898
150001	21.6990	22.8109	24.0620	22.8643
150002	18.7568	19.3401	20.7651	19.6416
150003	19.3117	19.7661	20.8636	19.9824
150004	19.7020	20.3685	21.2449	20.4349
150005	18.9964	20.6260	21.6806	20.4380
150006	20.0433	20.8158	20.6523	20.5130
150007	19.5255	20.1826	20.6635	20.1487
150008	20.9684	21.4545	21.8457	21.4285
150009	18.2168	18.7073	19.0030	18.6289
150010	18.4776	21.7125	20.5570	20.1836
150011	19.1957	18.3742	18.3275	18.6280
150012	20.5193	22.4751	22.1402	21.6785
150013	16.0043	17.0352	16.9327	16.6522
150014	21.2812	22.0143	21.5168	21.6212
150015	22.0452	22.5409	21.9037	22.1546
150017	18.8898	18.7664	19.5339	19.0694
150018	19.5612	20.4947	21.0496	20.3869
150019	15.2892	16.6327	17.8585	16.5672
150020	14.4592	15.1120	16.6600	15.3745
150021	19.0162	19.5096	21.5944	20.0447
150022	17.9206	19.1555	17.9222	18.3309
150023	18.6641	18.3598	19.3412	18.8110
150024	17.8311	18.4140	19.2295	18.4561
150025	18.1490	17.7007	20.2750	18.6347

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
150026	20.5085	18.8417	22.4978	20.5355
150027	16.4846	17.3284	18.0335	17.2600
150029	21.7414	23.0546	23.2454	22.7440
150030	17.3296	17.9992	19.2406	18.1943
150031	18.0060	17.2429	18.3463	17.8675
150032	20.6391	*	*	20.6391
150033	21.6854	21.8768	22.6741	22.0835
150034	21.2868	22.1317	23.1533	22.1845
150035	19.8177	20.4477	21.2374	20.5107
150036	20.3848	20.8692	21.4567	20.9448
150037	17.7868	21.7109	24.4611	21.1306
150038	20.2503	21.2193	22.0572	21.2025
150039	17.4919	18.4729	19.6215	18.5025
150042	17.1241	18.1632	20.2221	18.3947
150043	17.9834	19.0120	20.1741	18.9948
150044	17.6432	18.4381	19.1309	18.4093
150045	17.0395	16.8121	18.1670	17.3563
150046	17.3210	17.6342	18.2543	17.7460
150047	24.8819	19.7441	22.0145	22.1013
150048	16.9573	19.3329	19.1648	18.5048
150049	16.8529	17.0141	18.6451	17.4705
150050	17.1442	16.8354	17.7354	17.2410
150051	18.1990	19.0130	19.7257	18.9710
150052	15.3618	15.8590	17.3750	16.2411
150053	18.7463	19.1421	18.8632	18.9165
150054	17.3296	17.3825	18.3916	17.7528
150056	23.2991	22.4087	21.5774	22.2457
150057	16.8630	16.5882	16.9736	16.8076
150058	20.9537	20.8178	22.1409	21.3058
150059	20.8004	21.2535	22.7360	21.5830
150060	16.0098	17.0743	18.6159	17.2538
150061	17.2141	17.3887	19.7968	18.0770
150062	18.4110	20.5415	20.8274	20.0239
150063	21.0899	22.0925	22.6525	21.9213
150064	17.0309	18.1400	20.3865	18.5718
150065	19.0051	19.8913	21.2153	20.0425
150066	14.5977	15.3373	19.5313	16.4634
150067	17.0829	18.2926	18.8862	18.0821
150069	17.3918	21.5310	23.3969	20.9447
150070	17.1992	17.9260	18.0827	17.7417
150071	14.7306	13.4760	13.5111	13.9122
150072	16.1091	16.2054	15.0765	15.7702
150073	19.0292	22.2968	*	20.5664
150074	18.8597	20.4175	20.2305	19.8210
150075	14.9786	15.5603	16.7532	15.7414
150076	22.3407	22.9382	22.6424	22.6387
150077	17.5750	*	*	17.5750
150078	19.0096	19.2718	19.9668	19.4018
150079	15.4545	17.2436	18.2051	16.9085
150082	17.8796	17.5265	17.8381	17.7489
150084	22.9159	23.2506	24.3107	23.4933
150086	17.3442	18.9735	18.3838	18.2534
150088	19.4475	18.9869	20.3366	19.5726
150089	22.9458	23.8791	22.1725	22.9671
150090	19.0595	20.7726	21.0945	20.2459
150091	19.8912	20.4053	22.4640	20.9087
150092	15.9174	16.7434	16.9179	16.5364
150094	18.3410	16.5788	17.5244	17.5067
150095	17.1187	17.1324	19.2749	17.7838
150096	20.0281	23.2764	20.8204	21.3056
150097	18.3103	19.3802	19.7751	19.1545
150098	14.2953	15.0943	15.2829	14.8856
150099	18.9718	22.4229	*	20.3545

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
150100	17.4776	18.4148	19.8066	18.6620
150101	17.5554	16.4604	20.6209	18.1130
150102	11.5034	19.7426	23.7180	17.1422
150103	17.3064	18.4781	18.7036	18.2137
150104	17.2642	17.6981	20.0765	18.3399
150105	19.1709	20.0431	22.4412	20.4692
150106	18.9097	16.1510	16.8714	17.2294
150109	18.2289	18.8077	19.9066	18.9623
150110	18.5752	18.6627	21.9336	19.5289
150111	16.1707	18.4556	19.2355	17.8619
150112	19.8155	20.4109	20.5253	20.2569
150113	19.1988	20.3780	19.6603	19.7455
150114	16.9638	19.5183	17.9877	18.1743
150115	17.0627	17.4315	18.4844	17.6591
150122	19.3545	18.7139	17.7867	18.6097
150123	15.1552	14.1105	14.0508	14.4522
150124	15.0706	14.6245	15.9487	15.2180
150125	20.3198	20.6735	21.3311	20.7806
150126	20.2958	21.3697	20.6857	20.7640
150127	22.8129	17.1994	17.0052	18.8048
150128	19.9205	18.5100	19.5576	19.3346
150129	23.4718	24.7711	28.6211	25.2796
150130	16.4144	18.1971	18.4846	17.6635
150132	19.4805	20.1684	20.9443	20.1836
150133	16.4910	17.3966	18.4250	17.4061
150134	17.0612	19.2526	19.3632	18.5912
150136	19.2819	20.1245	21.8097	20.3987
150145	*	16.6851	*	16.6851
150146	*	*	19.0204	19.0204
160001	19.0279	18.6035	19.0085	18.8767
160002	15.3724	15.9534	16.6003	15.9668
160003	15.7747	16.0862	16.2208	16.0221
160005	15.2320	17.6153	17.9405	16.9144
160007	15.6638	13.2101	15.1738	14.6237
160008	14.9698	15.9742	16.6193	15.8477
160009	16.0919	16.8391	17.9886	16.9591
160012	16.5409	16.4827	16.7112	16.5761
160013	17.0602	18.3996	18.6304	18.0298
160014	15.0861	15.9086	16.7146	15.8981
160016	18.3710	19.6322	19.9747	19.3376
160018	14.1634	14.5946	15.6141	14.7975
160020	14.4135	15.4712	15.5384	15.1417
160021	15.4860	16.5049	16.7617	16.2368
160023	14.2015	15.0665	15.0099	14.7723
160024	18.9548	19.7050	19.4764	19.3806
160026	18.6624	18.8379	19.5260	19.0040
160027	15.7403	16.3477	16.9417	16.3376
160028	20.5416	19.9595	21.0000	20.4893
160029	20.4003	20.4678	21.3457	20.7382
160030	17.9860	19.9508	19.6182	19.1837
160031	15.2831	15.2448	16.1267	15.5484
160032	16.1820	17.3202	18.3168	17.2888
160033	18.3736	18.8673	18.8859	18.7219
160034	14.5053	15.0019	16.5957	15.3739
160035	15.9199	15.2211	16.3991	15.8029
160036	19.1984	17.8849	17.4558	18.1820
160037	18.3968	19.0532	19.5045	18.9883
160039	17.6272	17.4758	17.8647	17.6551
160040	16.8295	18.1949	18.0667	17.6917
160041	15.4700	16.7850	17.4435	16.5782
160043	15.6261	15.6909	14.8564	15.3356
160044	16.0385	16.7439	17.8323	16.9072
160045	20.1154	20.1236	20.0611	20.1010

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
160046	14.7672	14.5655	16.2737	15.1831
160047	16.6926	18.3593	19.0787	18.0537
160048	13.1417	14.6144	15.6856	14.5140
160049	13.3614	14.5457	15.5673	14.5017
160050	16.4161	17.4912	17.7878	17.2198
160051	14.2660	14.6400	16.4261	15.1036
160052	17.5509	18.0941	21.7647	19.2313
160054	15.7093	16.1753	16.1981	16.0321
160055	14.0647	14.7600	15.1674	14.6539
160056	15.3758	16.1575	17.0172	16.1537
160057	17.4101	18.1776	19.1378	18.2553
160058	20.3402	21.1159	22.1061	21.1598
160060	15.9527	16.0436	17.2825	16.3968
160061	17.5707	17.3215	17.0938	17.3350
160062	14.4433	17.8086	17.4388	16.4393
160063	16.2960	16.8834	16.3583	16.5061
160064	19.9135	20.5496	22.2131	20.9171
160065	16.5087	16.9373	17.1043	16.8758
160066	16.2651	17.1875	17.9971	17.1716
160067	17.8551	17.8514	16.7833	17.4322
160068	15.8526	17.9892	19.0572	17.5565
160069	18.4857	19.7280	19.1640	19.1095
160070	15.6647	16.7017	18.4588	16.9299
160072	14.1920	14.9536	14.4141	14.5422
160073	15.0526	11.8261	11.4997	12.6736
160074	16.4772	19.5092	17.9513	18.0038
160075	17.8870	19.4948	18.4613	18.6342
160076	17.3086	17.9381	17.8824	17.7060
160077	11.4028	12.8826	13.6658	12.6451
160079	17.7050	17.6187	18.6333	17.9899
160080	17.8143	18.6687	19.4925	18.6704
160081	16.5150	17.0052	17.4466	17.0164
160082	18.7630	19.6499	19.5322	19.3143
160083	18.4078	20.6189	19.7542	19.5937
160085	18.5510	18.0063	21.2557	19.2281
160086	16.4558	17.3271	17.5308	17.0998
160088	17.5331	20.2331	22.3655	19.9346
160089	16.7419	16.9538	17.3449	17.0079
160090	16.6002	17.1090	17.9614	17.2461
160091	12.1893	12.8516	14.2573	13.0755
160092	15.7979	15.5011	17.0633	16.0971
160093	15.9525	17.7457	18.5675	17.5141
160094	16.5609	18.7653	17.6094	17.6731
160095	14.2649	15.1895	15.2722	14.9322
160097	15.2079	15.9263	16.6790	15.9380
160098	15.5385	16.3135	16.8670	16.2509
160099	13.7864	13.9053	15.0880	14.2533
160101	17.8654	18.3705	18.9788	18.3824
160102	18.3631	18.8765	20.1161	19.0875
160103	17.1519	17.0973	18.2741	17.4869
160104	19.7387	18.8301	17.4829	18.7797
160106	16.6624	16.9639	17.3474	16.9910
160107	16.5622	18.0634	18.0097	17.5762
160108	15.4183	16.0529	16.7779	16.0861
160109	16.4885	16.5593	17.9873	16.9740
160110	18.8056	19.1420	20.6215	19.5351
160111	13.1689	14.1644	14.9965	14.0808
160112	16.2829	16.8332	17.2450	16.7911
160113	14.5838	14.7097	15.4834	14.9308
160114	15.5812	16.1423	16.5006	16.0651
160115	15.7566	15.8995	16.5654	16.0764
160116	16.6927	16.9534	16.6993	16.7818
160117	17.2914	17.9410	18.7615	17.9848

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
160118	15.8351	17.2523	19.4472	17.5046
160120	12.5642	10.5992	15.6789	12.4454
160122	18.5214	18.9252	18.1469	18.5357
160124	17.1642	18.0908	19.1600	18.1198
160126	17.7397	17.8142	19.4903	18.3068
160129	15.8914	16.7131	17.2112	16.5953
160130	15.4477	16.0528	15.6666	15.7242
160131	14.6874	15.4898	16.0424	15.4292
160134	13.3246	13.4743	15.3012	14.0359
160135	16.3294	18.2682	18.7711	17.7744
160138	15.7076	16.8699	17.1491	16.5906
160140	18.7962	18.4007	18.5630	18.5823
160142	16.1372	16.2875	18.1467	16.8318
160143	15.9240	16.6154	17.4497	16.6799
160145	15.1745	13.9152	16.9092	15.2763
160146	16.3532	16.6024	17.7010	16.8728
160147	18.3917	17.4880	19.4041	18.3938
160151	15.7384	16.8257	17.2177	16.5833
160152	15.2179	15.6170	15.9500	15.5914
160153	19.6927	20.2316	21.2085	20.3741
170001	17.4383	17.9304	17.9218	17.7616
170004	13.0635	15.0636	16.1442	14.7434
170006	19.3075	17.2192	17.5982	17.9438
170008	13.9009	14.9124	16.8412	15.1327
170009	19.5867	20.7795	23.1349	21.2143
170010	17.8995	18.7384	19.4584	18.6890
170012	16.7886	17.8719	18.4432	17.7137
170013	17.8949	18.6454	19.4667	18.6963
170014	17.3379	17.9349	18.4931	17.9333
170015	15.8887	16.5750	17.1302	16.5216
170016	19.6393	19.2130	20.0675	19.6307
170017	17.8690	17.7958	19.5994	18.4143
170018	14.2759	15.2984	15.3237	14.9817
170019	16.6611	15.2094	16.9362	16.2597
170020	16.1460	17.3400	18.1325	17.2351
170022	17.9383	18.5309	19.1888	18.5543
170023	19.3585	19.1351	19.2441	19.2444
170024	13.0566	13.6803	14.3604	13.6835
170025	16.3716	17.8667	18.7182	17.6087
170026	13.3122	15.0470	14.8974	14.3412
170027	16.3859	17.3604	17.8690	17.2095
170030	15.2397	14.6530	15.9282	15.2488
170031	13.4670	13.9601	14.2151	13.8715
170032	14.4835	15.6093	16.3449	15.4817
170033	16.0529	16.4059	19.1952	17.1087
170034	14.6349	15.8202	16.9586	15.7633
170035	15.6240	18.5885	17.0945	17.0832
170036	14.1732	*	*	14.1732
170038	14.2092	14.7776	13.8582	14.2922
170039	14.2952	15.8635	17.0774	15.7642
170040	20.1419	21.6440	21.0617	20.9374
170041	11.4691	11.7566	12.4488	11.8690
170044	14.7801	15.3011	17.3254	15.8168
170045	12.1066	14.0875	25.8331	16.7874
170049	18.5821	19.9415	20.7921	19.8083
170051	14.1572	15.0889	16.4851	15.2703
170052	14.6176	15.0108	15.2283	14.9500
170053	9.0407	16.5102	14.6133	11.9759
170054	12.7655	14.4353	14.6354	13.9214
170055	14.9875	16.9800	18.2607	16.7698
170056	14.8656	17.0442	18.3550	16.8283
170057	15.0892	13.0007	*	13.9776
170058	18.3389	18.6983	19.5415	18.8159

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
170060	17.2271	17.3482	18.9853	17.7512
170061	14.1380	15.6527	15.0258	14.9459
170063	11.3284	12.8082	14.1185	12.6216
170064	12.4183	*	*	12.4183
170066	14.4790	15.5322	16.2891	15.4168
170067	12.7846	14.7492	14.9921	14.1535
170068	15.8175	15.1790	17.0022	15.9795
170070	12.8158	14.2445	14.0627	13.7083
170072	13.3379	12.6329	12.7709	12.9159
170073	16.4690	17.5368	17.7056	17.2186
170074	14.4009	17.5537	17.3699	16.4326
170075	11.2598	12.4212	13.6816	12.5950
170076	13.5820	14.5866	14.6109	14.2394
170077	12.7244	13.5235	13.9104	13.3651
170079	14.2859	13.5261	11.5902	13.1470
170080	12.2012	12.6014	14.8293	13.1562
170081	12.5122	13.8077	14.6823	13.7421
170082	12.3902	12.8563	13.7462	12.9854
170084	12.1611	12.5410	13.0519	12.5742
170085	14.5069	15.4518	17.5422	15.9150
170086	19.8496	20.4068	19.7182	19.9991
170088	11.7505	13.4542	13.4860	12.9031
170089	18.0823	18.8136	15.4860	17.4574
170090	11.2747	11.9147	10.9444	11.3947
170092	12.8507	*	*	12.8507
170093	12.7780	13.5490	14.0276	13.4193
170094	17.7091	20.1985	21.2035	19.6936
170095	15.7469	15.5463	15.3532	15.5482
170097	15.8504	16.4608	17.7540	16.7203
170098	14.1026	15.5259	16.6210	15.4425
170099	13.5509	13.6033	14.3370	13.8072
170100	14.4700	*	*	14.4700
170101	12.8847	14.5629	18.0143	14.7718
170102	13.2434	13.6321	14.2447	13.7065
170103	16.6578	17.2844	17.9530	17.2887
170104	19.7645	20.6182	21.0049	20.4661
170105	15.9290	16.5408	16.7403	16.4083
170106	14.6773	18.5479	17.7467	16.9030
170109	16.9421	17.2629	16.9782	17.0622
170110	15.5549	16.9823	18.5731	17.1658
170112	13.3908	14.3855	15.4049	14.4270
170113	13.3935	13.9038	14.6486	13.9920
170114	14.5116	14.4545	16.2645	15.0138
170115	12.6815	12.6997	12.9216	12.7709
170116	15.7566	16.8714	18.1830	16.9494
170117	15.2818	15.7875	16.8237	15.8968
170119	13.9673	15.1990	15.2708	14.7822
170120	16.2122	17.6748	17.4917	17.1241
170122	20.1266	20.0615	21.1769	20.4366
170123	21.4168	23.1697	23.6534	22.7009
170124	10.2089	11.1249	15.0596	11.8247
170126	12.1268	12.8096	13.5736	12.8129
170128	14.9919	14.8891	14.1676	14.6301
170131	13.0978	10.1000	*	11.3849
170133	17.1103	18.0243	18.8119	17.9917
170134	14.2252	14.1085	14.6799	14.3402
170137	17.4151	17.8290	19.3118	18.1884
170139	13.3896	14.1967	14.3001	13.9545
170142	17.3234	*	17.7134	17.5177
170143	15.8802	15.6509	16.0415	15.8575
170144	16.0860	19.0929	20.4392	18.4073
170145	16.7499	17.1837	19.0142	17.6442
170146	19.9725	20.9075	21.7919	20.9132

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
170147	16.2829	22.3017	17.6717	18.6905
170148	17.2497	16.9183	19.1942	17.6867
170150	15.4283	15.5651	15.9072	15.6422
170151	13.3674	13.8934	14.3668	13.8637
170152	13.6846	14.9139	15.6423	14.7323
170160	13.3087	13.7108	14.4732	13.8369
170164	15.5597	16.6542	17.4072	16.5279
170166	17.5681	27.5567	12.7507	18.3396
170171	13.8059	12.5200	13.1792	13.1761
170175	17.8802	19.0232	20.1907	18.9985
170176	20.3194	21.3400	23.5043	21.7098
170180	*	16.6921	8.6352	11.8552
170182	14.1971	22.2164	21.3454	19.8791
170183	19.0919	20.3505	19.5182	19.7036
170184	27.0152	*	*	27.0152
180001	19.5188	17.9906	20.4885	19.3882
180002	18.1348	17.9669	17.5798	17.8819
180004	15.9921	17.2581	17.7149	16.9654
180005	20.6280	21.1390	22.4634	21.3796
180006	11.2254	11.4398	10.3400	11.0123
180007	17.1997	17.6776	17.9491	17.6005
180009	20.8103	21.4730	21.0608	21.1163
180010	17.5452	19.1100	19.6311	18.7406
180011	16.9311	17.1050	19.0526	17.8588
180012	18.7350	18.7223	19.0646	18.8428
180013	17.4487	18.2354	19.7418	18.5305
180014	20.8033	21.4856	21.3361	21.1759
180016	18.8422	19.8892	21.1458	20.0187
180017	15.1699	15.4140	15.6583	15.4240
180018	18.9020	17.1692	15.4892	17.0584
180019	16.7648	17.3970	17.8285	17.3565
180020	17.7782	17.7288	18.0111	17.8397
180021	15.1627	15.4580	17.0618	15.8957
180023	15.2219	15.8803	17.4717	16.1885
180024	15.3299	16.1731	16.5040	15.9951
180025	17.1688	14.1841	15.4180	15.4826
180026	14.1571	14.6804	15.0118	14.6082
180027	14.8869	16.4116	17.5286	16.2087
180028	19.3519	19.5276	15.7005	18.0068
180029	18.0191	17.7729	17.7248	17.8352
180030	17.0234	17.3430	17.9543	17.4342
180031	13.7862	13.9844	13.1848	13.6178
180032	16.0941	16.8318	17.2784	16.7976
180033	13.7667	17.7344	15.4131	15.5472
180034	17.3158	15.3369	16.3991	16.3000
180035	19.4485	20.1305	21.3666	20.2870
180036	19.1922	19.8398	20.1860	19.7448
180037	18.8053	19.9737	21.2184	19.9797
180038	17.1643	17.7626	18.5923	17.8512
180040	19.4450	19.5337	21.2229	20.0583
180041	15.1703	15.0785	16.3699	15.5655
180042	16.2924	16.7691	17.1519	16.7450
180043	16.6077	16.8027	14.6526	15.9643
180044	17.8196	18.5571	19.4984	18.6534
180045	17.7272	17.7130	20.8455	18.9499
180046	17.9096	19.2523	21.2080	19.4569
180047	15.0354	16.2304	18.6938	16.6027
180048	19.5681	18.3442	17.7816	18.5208
180049	16.0799	16.4319	16.5459	16.3594
180050	18.4753	17.8540	17.1493	17.7884
180051	15.6796	16.3960	17.5441	16.5170
180053	14.6299	15.9284	15.8994	15.5002
180054	16.3875	19.4858	20.0946	18.5771

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
180055	14.6446	15.2663	15.8422	15.2446
180056	16.6240	17.0056	17.5881	17.0744
180058	14.3562	15.9685	14.5355	14.9226
180059	14.2605	13.3955	14.7032	14.1102
180060	7.2139	*	*	7.2139
180063	11.9120	13.1036	12.4448	12.4785
180064	14.4872	15.2424	15.5066	15.0871
180065	20.0286	12.0629	11.1934	13.8815
180066	18.5635	19.2981	19.8956	19.2578
180067	18.5288	20.6322	20.1712	19.7577
180069	17.2956	17.7911	16.2916	17.1149
180070	13.8370	13.1923	15.9362	14.2840
180072	17.8554	16.9021	17.2347	17.3229
180075	15.0701	*	*	15.0701
180078	19.1615	21.1170	21.7116	20.6787
180079	13.4072	15.1636	15.9048	14.8197
180080	15.8327	16.4989	16.6428	16.3363
180087	14.9660	14.9167	15.6089	15.1555
180088	22.5349	22.0374	22.1774	22.2484
180092	16.3099	18.2405	18.3597	17.6633
180093	16.8286	17.0132	17.8492	17.2232
180094	12.5074	13.5490	13.6233	13.2263
180095	13.3991	13.8021	13.9050	13.6989
180099	13.6988	13.3631	13.2991	13.4593
180101	19.5644	18.4883	*	18.9778
180102	17.8751	17.9618	18.5240	18.1008
180103	19.2182	19.8965	20.3490	19.8359
180104	18.8730	18.9281	19.3922	19.0643
180105	14.0811	15.2394	16.6997	15.2994
180106	13.6062	14.3505	15.2895	14.3903
180108	14.6222	14.8187	14.4740	14.6381
180115	17.1079	16.7003	16.9096	16.9026
180116	16.9389	18.0392	18.6077	17.8709
180117	18.3821	17.7857	23.0192	19.6584
180118	12.1533	15.8597	16.9250	14.8270
180120	17.8145	16.1591	15.3115	16.3371
180121	14.5134	15.0983	20.0494	16.3330
180122	16.9678	18.5094	18.1930	17.8754
180123	18.9995	21.0613	21.1067	20.4023
180124	18.4064	17.4994	18.8487	18.2269
180125	19.7341	19.6416	14.9314	17.5744
180126	12.3959	12.9228	14.3551	13.2733
180127	17.3452	19.2581	17.6365	18.0663
180128	17.0508	17.6385	18.2817	17.6802
180129	17.8600	16.8378	22.3536	18.8696
180130	19.0110	19.8192	20.6450	19.8370
180132	17.2657	17.7744	19.5884	18.2006
180133	22.2325	21.6794	21.7800	21.8995
180134	13.6287	13.1935	14.5387	13.7967
180136	17.7146	17.3542	*	17.5359
180138	18.6149	19.3692	20.2102	19.4170
180139	18.7679	18.7198	20.5350	19.3756
180140	20.3953	16.8152	15.2719	17.3915
180141	20.0075	20.9820	23.8930	21.4590
180142	*	*	20.7510	20.7510
190001	17.0159	17.6832	18.1514	17.6263
190002	18.8381	19.1924	19.8834	19.2931
190003	22.1543	19.7749	19.9121	20.4811
190004	17.5385	17.7710	18.3620	17.8959
190005	16.7149	17.2422	17.5161	17.1568
190006	17.7335	17.8036	17.5911	17.7112
190007	13.6014	13.8189	14.4720	13.9833
190008	16.8916	18.6664	19.2456	18.2327

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
190009	14.2085	15.3555	15.9731	15.1819
190010	17.0192	16.2805	16.5020	16.6088
190011	15.1715	15.9534	15.6351	15.5881
190013	16.5706	16.8181	15.5019	16.2739
190014	17.0170	17.0959	17.8015	17.3107
190015	18.1943	18.6266	18.9896	18.6153
190017	15.7894	16.2393	17.5381	16.5250
190018	16.9761	15.0668	11.1898	14.5841
190019	17.4006	18.5257	18.3788	18.1281
190020	17.3084	17.5256	17.6840	17.5059
190025	16.0738	18.6369	16.8686	17.2271
190026	17.2166	18.1622	18.5015	17.9532
190027	16.1856	17.0827	17.4761	16.9034
190029	17.1103	16.5239	19.1967	17.5497
190033	10.7448	*	*	10.7448
190034	16.5066	16.8503	18.0754	17.1513
190036	19.9456	20.1780	20.0300	20.0491
190037	12.0237	17.6945	19.9878	16.0686
190039	17.1687	19.4713	19.0376	18.5119
190040	20.3180	21.4634	21.7376	21.1907
190041	17.8975	17.6646	17.9535	17.8382
190043	12.5660	15.5580	15.5618	14.5094
190044	17.1984	17.2892	17.4471	17.3108
190045	21.6948	21.6107	21.2853	21.5139
190046	19.3538	19.7964	20.4458	19.8736
190048	16.3404	16.6683	16.8136	16.6153
190049	16.4250	17.2280	17.7417	17.1570
190050	15.3771	16.1980	16.2854	15.9545
190053	12.4980	13.2159	13.0080	12.9160
190054	16.4683	19.1738	18.9059	18.1924
190059	15.8443	15.6942	15.8373	15.7915
190060	18.3689	14.7186	17.8443	16.7639
190064	19.9047	20.4482	18.2466	19.4909
190065	19.3856	20.9927	18.3091	19.5174
190071	13.5908	14.4827	16.4138	14.8320
190077	12.8290	15.7805	16.5536	15.0793
190078	13.4990	14.8826	16.9383	14.8793
190079	17.2909	17.7120	17.9403	17.6368
190081	12.0190	15.3198	14.9707	14.2301
190083	16.1374	18.8895	18.4951	17.8399
190086	14.9295	15.8694	16.5074	15.7738
190088	19.6328	20.5531	19.9362	20.0391
190089	12.7879	13.0503	15.0395	13.5823
190090	16.5580	16.6664	16.2351	16.4928
190092	18.0655	*	*	18.0655
190095	15.7316	16.2287	17.3258	16.3915
190098	19.2175	20.4897	21.0847	20.2301
190099	18.9255	19.9018	19.0635	19.3257
190102	19.0477	20.0300	20.7870	19.9631
190103	15.5698	12.1389	14.4158	13.8580
190106	17.7468	18.5813	18.5908	18.3281
190109	14.5288	15.5767	15.8187	15.3068
190110	12.9925	15.8052	15.7313	14.8387
190111	20.0376	19.7514	20.6508	20.1574
190112	19.2067	21.0232	22.0741	20.6951
190113	18.9922	12.5777	*	15.7380
190114	12.9083	12.6366	13.9209	13.1568
190115	20.4914	20.2473	22.7583	21.1252
190116	12.5881	15.5481	17.3757	15.1678
190118	12.9537	14.7876	16.3776	14.7222
190120	13.6938	13.9591	17.2309	14.9846
190122	14.8255	15.4793	15.3742	15.2287
190124	22.3825	20.6222	20.1206	20.9375

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
190125	18.6287	20.4517	19.8298	19.6458
190128	19.7127	20.4688	20.8770	20.3583
190130	12.4307	15.1467	14.0379	13.8956
190131	19.5984	20.7565	18.8958	19.7536
190133	13.4750	13.5383	15.1393	13.9917
190134	12.6774	12.1749	12.4507	12.4351
190135	21.3511	21.6875	21.3454	21.4650
190136	11.3250	12.4091	15.1662	13.0730
190138	22.7088	*	*	22.7088
190140	12.0285	14.2256	14.6829	13.6611
190142	14.9820	15.4861	16.2280	15.5517
190144	16.8360	16.2068	18.4405	17.1561
190145	13.9893	15.2345	16.2505	15.1638
190146	20.0941	21.2825	21.9607	21.1552
190147	14.3219	14.4345	14.7202	14.4910
190148	14.0180	16.6337	15.5338	15.4604
190149	15.1862	17.5997	16.4722	16.4169
190151	11.9190	14.7333	15.5210	14.0028
190152	20.3951	22.2070	22.0319	21.4716
190155	11.0800	*	*	11.0800
190156	12.4786	15.7478	16.0442	14.6766
190158	19.6164	20.4637	20.4078	20.1474
190160	18.4746	17.1003	18.4662	18.0078
190161	14.6295	15.5737	15.9280	15.3544
190162	19.5027	20.6143	20.1962	20.0440
190164	16.3328	15.1783	18.2379	16.4778
190167	16.2880	16.6681	17.7611	16.9143
190170	13.5772	14.1750	14.5222	14.0895
190173	19.6362	23.6398	23.0934	22.0602
190175	20.6908	19.3625	20.4580	20.1298
190176	18.8205	24.0574	22.2316	21.4596
190177	20.3177	18.6715	19.7794	19.5846
190178	10.4941	11.0657	12.0372	11.1714
190182	20.0267	20.2855	20.7102	20.3281
190183	16.1064	16.7671	16.0752	16.3134
190184	14.8645	17.2044	19.8436	17.2547
190185	19.3707	20.1444	20.5852	20.0405
190186	16.3586	18.7568	17.4078	17.5306
190189	26.5419	*	*	26.5419
190190	18.6656	17.4642	15.8985	17.1134
190191	18.1353	20.4975	19.6911	19.4475
190196	14.8699	17.9225	18.6138	17.2784
190197	17.9166	19.5569	20.2082	19.2721
190199	13.4222	16.0637	15.3522	14.6078
190200	19.4148	22.0391	21.6852	21.0397
190201	19.1432	18.7079	19.7421	19.2055
190202	17.8959	*	*	17.8959
190203	21.3096	21.7350	21.7931	21.5975
190204	21.2119	21.4624	20.5784	21.0754
190205	18.1007	19.6587	19.3737	19.0483
190206	20.0648	21.7012	21.3307	21.0222
190207	17.6712	20.5082	19.0216	19.1034
190208	14.6096	20.0065	16.9641	17.1855
190218	18.1627	19.7518	19.2992	19.0335
190223	19.2550	*	*	19.2550
190227	12.1086	*	*	12.1086
190231	16.8850	15.8287	17.7247	16.7665
190235	18.2702	*	*	18.2702
190236	22.1837	19.3395	21.1982	20.9440
190238	*	*	20.6799	20.6799
190239	*	*	19.7601	19.7601
190240	*	*	14.3579	14.3579
200001	17.4890	18.0527	18.2513	17.9448

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
200002	18.7745	19.3629	22.3035	20.2028
200003	16.7389	16.9566	18.4141	17.3782
200006	19.7984	17.6586	21.0922	19.4856
200007	17.8859	18.7992	18.1681	18.2871
200008	20.5020	21.7489	21.5556	21.2780
200009	20.6433	22.2280	21.4763	21.4574
200012	17.0130	18.3484	19.1047	18.1711
200013	16.4933	18.0566	17.9378	17.5422
200015	20.1117	*	*	20.1117
200016	17.6623	18.0866	17.1187	17.6192
200017	19.6462	17.2930	*	18.7598
200018	17.2422	18.5397	17.8675	17.8479
200019	18.6399	19.2348	19.9245	19.2946
200020	20.5967	22.4526	22.3355	21.8088
200021	19.4052	19.9133	20.7361	19.9988
200023	14.9164	16.1707	20.2063	16.7560
200024	18.6518	19.4329	20.8336	19.6454
200025	19.0659	20.2259	20.4165	19.9282
200026	17.2842	18.1194	17.9021	17.7766
200027	18.2775	18.5659	19.4220	18.7949
200028	16.9306	19.5708	18.8763	18.4290
200031	15.9043	16.2217	16.1641	16.1005
200032	17.9160	18.9315	19.4613	18.7411
200033	21.4031	21.8634	22.4685	21.9155
200034	19.2407	20.1519	20.4941	19.9680
200037	18.2419	18.6713	20.3015	19.1236
200038	19.2147	23.3851	21.2632	21.2824
200039	20.2901	19.8589	20.1508	20.0694
200040	19.2970	19.5503	18.9580	19.2627
200041	17.6559	19.3563	18.8131	18.6006
200043	16.5368	16.7224	19.4295	17.5199
200050	18.0805	20.1214	20.2014	19.5017
200051	19.5925	22.1525	22.0712	21.5149
200052	15.1216	17.2099	17.6271	16.6895
200055	17.1729	18.8422	18.5983	18.1835
200062	16.5139	17.2273	18.4279	17.3769
200063	19.6658	19.9331	21.2121	20.2562
200066	16.3431	17.0289	17.0570	16.8076
210001	18.7266	20.4841	18.6617	19.2372
210002	22.8448	19.9219	23.5132	22.2827
210003	25.3730	20.3446	26.0447	23.6583
210004	23.5884	24.2909	24.9760	24.2880
210005	19.6162	21.4929	21.3829	20.7876
210006	17.7721	18.9436	19.3682	18.7016
210007	21.5415	23.1007	23.8840	22.8043
210008	19.5006	21.1768	21.2895	20.6531
210009	21.8111	20.5447	20.7479	21.0282
210010	14.3783	18.7197	19.5908	17.3758
210011	21.2422	21.4862	21.4043	21.3727
210012	23.4317	20.7203	21.3977	21.7764
210013	18.8455	19.7288	19.4505	19.3405
210015	16.6898	16.1912	18.7448	17.2340
210016	22.1469	23.8739	26.5193	24.0991
210017	17.1747	18.8928	18.5079	18.1448
210018	21.4055	22.2135	22.8553	22.1574
210019	19.0899	19.3046	20.6025	19.6453
210022	21.8160	22.6389	24.5744	23.0098
210023	21.7988	23.1950	22.9989	22.6719
210024	19.5645	20.6011	24.4280	21.4080
210025	19.5704	19.5876	21.2769	20.0208
210026	11.6440	12.1348	13.8668	12.6171
210027	18.4862	17.6855	17.1060	17.7943
210028	18.8623	19.6408	19.4157	19.3091

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
210029	22.3876	21.2167	25.4939	23.0892
210030	21.0169	21.7403	20.9574	21.2261
210031	15.5873	16.2299	*	15.9014
210032	18.4983	17.7228	20.1955	18.7972
210033	19.9144	20.8053	23.7588	21.3886
210034	16.1216	15.7322	19.4144	17.1228
210035	20.6092	20.2731	20.8317	20.5720
210037	18.7361	18.3072	20.5528	19.2053
210038	23.2616	23.4971	24.9762	23.8679
210039	20.7291	19.9901	21.3559	20.7067
210040	25.0770	21.5014	23.4252	23.3184
210043	18.5891	19.6474	22.4000	20.0973
210044	22.2438	22.5781	23.0917	22.6329
210045	9.6862	11.6086	12.1467	11.1781
210048	22.3923	23.0537	24.6921	23.3434
210049	17.6697	19.0821	19.3022	18.6991
210051	20.7633	22.4335	23.6476	22.3235
210054	23.5122	22.3559	23.2730	23.0396
210055	20.1012	29.2539	26.5272	25.0062
210056	20.9445	19.2662	22.9593	21.0605
210057	22.5717	23.8289	26.0076	24.0668
210058	21.4976	22.0753	16.3191	20.0884
210059	23.1274	22.6766	25.6052	23.5899
210060	*	*	26.5846	26.5846
210061	20.0203	17.2240	16.1931	17.8181
220001	26.3207	21.9369	22.9064	22.9526
220002	22.5808	24.1285	16.3789	20.4063
220003	19.1383	16.9246	17.9319	17.9948
220004	20.0058	*	*	20.0058
220006	22.1228	22.3085	22.6337	22.3566
220008	21.8873	24.4691	22.0796	22.7689
220010	21.9226	21.8582	22.0067	21.9297
220011	28.5673	26.1827	29.5290	28.2047
220012	29.5051	32.0829	31.2303	30.9286
220015	21.7813	22.5773	23.1893	22.4843
220016	23.1440	23.3750	23.0951	23.2050
220017	25.2630	22.4605	25.1568	24.2781
220019	19.1264	19.5613	19.8551	19.5190
220020	19.9925	21.4152	22.4295	21.2738
220021	23.6313	*	*	23.6313
220023	18.7625	16.1885	*	18.0910
220024	21.5871	21.5363	21.9316	21.6947
220025	19.9398	20.7882	22.8593	21.1235
220028	22.0721	22.8036	21.0630	21.9530
220029	21.8711	23.1509	25.6560	23.4858
220030	14.5383	18.5441	18.7429	17.2580
220031	28.1584	30.2430	29.3091	29.1415
220033	20.4120	20.0695	20.3609	20.2712
220035	21.9974	21.6396	23.1892	22.2365
220036	24.1570	24.6470	24.4091	24.3977
220038	22.3494	22.6518	22.3162	22.4382
220041	23.1483	23.4720	27.5034	24.5999
220042	25.2852	25.0779	26.0473	25.4181
220046	22.4677	22.7068	23.3149	22.8459
220049	23.0283	26.0025	27.2689	25.4891
220050	20.8345	22.0144	22.5265	21.7871
220051	20.4765	21.1033	21.7357	21.0973
220052	23.1376	23.7650	23.5225	23.4708
220053	21.2679	19.1280	*	20.2813
220055	21.5706	21.3743	*	21.4727
220057	23.0010	25.3902	25.8064	24.6606
220058	20.1888	19.9369	26.8345	22.1915
220060	26.1753	28.0843	28.0794	27.4392

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
220062	20.0560	20.4685	20.2254	20.2505
220063	20.9547	20.3951	20.8079	20.7132
220064	22.1785	22.3260	22.7497	22.4060
220065	20.1974	20.1364	20.1424	20.1584
220066	20.4586	20.7826	23.4477	21.6604
220067	25.7414	26.4443	27.5405	26.5452
220068	6.4548	*	*	6.4548
220070	19.7678	19.7528	20.9128	20.1099
220071	24.6508	25.6184	27.4151	25.8715
220073	25.8680	25.6025	26.1328	25.8683
220074	24.0523	25.6390	24.3057	24.7411
220075	21.5418	22.8057	22.5329	22.2794
220076	24.7783	22.6668	23.2795	23.6106
220077	24.8019	25.2646	26.1545	25.3933
220079	21.0090	22.6256	22.0769	21.8560
220080	20.5007	21.5238	22.1971	21.3825
220081	25.3370	29.1726	29.6682	28.0686
220082	20.0175	21.6726	22.1453	21.2140
220083	23.0759	23.9156	22.5815	23.1732
220084	24.6624	23.6641	25.3761	24.5459
220086	30.4649	23.8705	26.7778	26.4452
220088	23.3783	22.9067	23.4258	23.2384
220089	21.7884	23.0965	25.4106	23.3099
220090	21.6353	22.0041	23.3049	22.2774
220092	17.0409	18.5239	24.7905	19.4783
220094	21.9853	*	*	21.9853
220095	21.4468	21.4831	21.7851	21.5735
220098	20.8596	21.5906	23.1547	21.8533
220100	25.3484	25.7077	27.5841	26.2007
220101	24.3260	25.9204	27.0711	25.7662
220104	27.5297	28.0021	28.7258	28.0695
220105	21.6873	21.4129	21.9185	21.6684
220106	24.5518	25.6577	25.9277	25.3659
220107	20.2719	*	*	20.2719
220108	22.6372	21.9115	23.4975	22.6709
220110	29.1927	28.7071	29.1648	29.0217
220111	23.0475	23.8066	24.7510	23.8707
220116	24.9744	26.1662	32.0049	27.4579
220118	30.5213	*	*	30.5213
220119	22.8586	23.3216	23.8785	23.3181
220123	27.3063	25.8994	32.4678	28.6276
220126	20.9557	22.5218	23.6045	22.3000
220128	20.5636	*	*	20.5636
220133	35.2747	25.4596	29.3911	30.0324
220135	25.0798	25.6522	28.3648	26.3313
220153	23.8981	22.9592	*	23.4152
220154	22.1261	22.4770	21.1563	22.0118
220163	27.3527	29.1143	29.2299	28.5578
220171	23.4340	24.5553	24.9261	24.3151
230001	19.2015	19.8020	20.0438	19.6841
230002	21.9058	22.7991	23.0439	22.5920
230003	19.6118	19.8420	21.2215	20.2501
230004	22.0310	23.1036	20.5005	21.8004
230005	19.4040	18.5644	17.0943	18.3438
230006	18.4681	19.1041	20.4978	19.3271
230007	19.4339	15.5538	*	18.1334
230012	18.6663	15.0803	*	16.5807
230013	20.6322	20.8018	22.2211	21.1847
230015	20.4264	20.1104	20.6464	20.3967
230017	20.3975	22.2822	22.9755	21.8495
230019	21.3222	22.2622	23.6674	22.4892
230020	21.3206	22.1280	21.8526	21.7774
230021	18.5670	18.9636	19.8256	19.1973

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
230022	19.7598	18.8006	21.9129	20.1618
230024	27.9551	23.7326	24.9664	25.4314
230027	18.0285	14.6950	19.6393	17.2624
230029	21.0636	19.4911	22.1782	20.9312
230030	17.7040	18.3916	18.6406	18.2548
230031	17.5352	19.3162	19.9465	18.8845
230032	20.6821	21.8845	24.8930	22.4347
230034	17.2302	19.0473	19.4366	18.6363
230035	17.5607	17.5109	17.7490	17.6051
230036	21.7565	23.2119	23.8398	22.9390
230037	19.0688	20.4747	23.2751	20.8659
230038	23.3876	23.5251	21.9692	22.9521
230040	20.3897	21.4393	20.7841	20.8605
230041	19.0278	20.3131	21.7364	20.3273
230042	19.4937	22.1043	21.3870	21.0005
230046	25.9482	25.5696	25.3206	25.6107
230047	20.6379	21.5381	22.3595	21.5205
230053	22.1781	25.4968	26.8917	24.7553
230054	19.5427	20.6963	20.8014	20.3482
230055	19.8381	20.7932	20.8492	20.4732
230056	16.4101	16.0766	17.8091	16.7213
230058	18.2349	20.4165	21.0303	19.9623
230059	19.5098	19.9240	20.7092	20.0517
230060	17.8716	19.8021	19.8987	19.1871
230062	16.2952	17.1540	18.8039	17.3634
230063	20.2211	20.4171	*	20.3143
230065	21.1507	22.3459	22.7416	22.2057
230066	21.5116	22.1768	23.0475	22.2618
230069	21.7909	23.2076	24.2470	23.0592
230070	20.0645	20.2505	21.5666	20.8098
230071	22.1556	22.9052	23.1337	22.7304
230072	20.4308	20.6944	20.4456	20.5245
230075	19.4316	20.0545	22.5866	20.6203
230076	23.8201	24.4547	24.7010	24.2886
230077	20.3937	21.0178	20.2823	20.5602
230078	16.2486	17.5577	17.9868	17.2435
230080	18.9084	19.7687	20.2104	19.6745
230081	17.9510	19.0345	19.0199	18.6644
230082	17.7417	18.2992	19.0419	18.3501
230085	17.5447	20.2096	23.4996	20.3924
230086	16.9754	18.9420	20.1730	18.6767
230087	15.7694	18.9034	19.9700	18.0112
230089	21.3914	23.9100	22.6994	22.6194
230092	18.9567	20.0145	20.7738	19.9304
230093	20.1928	20.4655	20.6314	20.4325
230095	16.7830	17.3313	17.6444	17.2565
230096	22.5613	22.8410	22.7785	22.7256
230097	20.0960	21.2854	21.1254	20.8481
230099	20.2529	21.1933	21.7513	21.0709
230100	13.1107	17.1336	17.3842	16.0298
230101	18.6098	20.0932	20.5315	19.7445
230103	19.6014	22.7696	11.3429	17.7532
230104	23.4703	23.1457	24.1238	23.5809
230105	20.8765	21.5210	22.6098	21.6727
230106	18.3508	20.7997	21.6825	20.2936
230107	14.6673	16.5966	17.1386	15.9949
230108	17.4231	18.8631	20.3437	18.8600
230110	17.8017	18.9825	19.7262	18.8384
230113	11.1676	14.9411	*	12.8926
230115	16.4728	18.4050	19.6281	18.1783
230116	16.3563	16.5419	14.5692	15.7763
230117	23.9389	25.9318	25.6797	25.1927
230118	21.7089	21.3028	20.6797	21.2068

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
230119	23.9568	21.1918	22.6555	22.5908
230120	19.6400	18.5264	20.3306	19.4421
230121	20.0786	20.3158	21.3342	20.5789
230122	18.0903	20.9078	*	19.5648
230124	18.8938	20.3608	18.9981	19.3961
230125	15.3497	*	*	15.3497
230128	23.5787	24.9081	24.0724	24.1436
230130	22.5204	23.5170	22.1775	22.7280
230132	26.1727	26.6386	26.1946	26.3381
230133	17.5688	17.6894	17.1058	17.4473
230134	15.3248	*	*	15.3248
230135	22.7401	22.5258	20.5637	22.0738
230137	18.3431	19.1813	*	18.7522
230141	23.0496	22.1299	22.4570	22.5592
230142	20.1242	22.2940	23.5621	21.8277
230143	16.4468	16.3043	16.7948	16.5112
230144	20.9906	22.1108	23.4237	22.1285
230145	16.5986	20.2542	19.2638	18.8354
230146	18.6293	20.5044	21.2260	20.1486
230147	20.5144	21.8496	23.2755	21.8616
230149	14.1740	20.7691	18.8005	17.7545
230151	20.8884	22.1713	23.3967	22.0865
230153	17.3280	19.5633	18.7403	18.5291
230154	14.5846	15.4456	15.4362	15.1635
230155	16.9857	17.2076	20.5409	18.1875
230156	23.6126	24.7587	25.6228	24.6740
230157	19.7197	20.3667	17.3571	19.2380
230159	18.8426	20.0749	*	19.3914
230162	17.7689	21.4636	21.7148	20.3064
230165	23.3147	23.0106	23.8881	23.4094
230167	20.3210	21.5048	22.9745	21.5685
230169	22.8606	23.0652	24.3874	23.4345
230171	14.9595	13.3863	17.1282	15.0778
230172	20.2191	20.6417	21.4675	20.7898
230174	20.8542	23.0272	22.7304	22.1820
230175	21.8097	16.8909	*	19.0428
230176	21.8618	22.7772	23.8204	22.8229
230178	16.0818	16.9156	17.3030	16.7485
230180	15.4837	15.8769	18.5744	16.6297
230184	17.2928	19.0604	19.7717	18.6605
230186	*	19.5337	15.7837	17.6806
230188	15.5563	15.7112	16.2975	15.8821
230189	15.9089	16.6838	17.9218	16.8493
230190	23.7134	26.8196	26.4687	25.7543
230191	17.1221	19.0013	18.4861	18.1647
230193	20.1805	19.7066	19.8287	19.9318
230195	22.3745	21.7775	22.9228	22.3732
230197	21.6184	24.0184	24.0854	23.1281
230199	18.4012	19.4451	20.6580	19.5586
230201	15.3206	17.2141	18.0787	16.9556
230204	22.9506	25.4181	23.4966	23.9387
230205	13.8861	14.3788	15.9314	14.6555
230207	20.3538	20.6375	21.2483	20.7256
230208	17.1501	16.0733	16.7454	16.6668
230211	17.5087	18.6744	21.8581	19.0214
230212	22.1370	23.3021	24.2611	23.2193
230213	15.3159	15.1908	15.5469	15.3407
230216	19.5921	20.3359	21.0710	20.3422
230217	20.9510	21.2707	22.2698	21.4978
230219	20.7018	19.1549	20.0442	19.9745
230221	21.5000	*	*	21.5000
230222	20.8430	22.1785	21.9711	21.6725
230223	21.4990	21.1528	22.6887	21.7715

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
230227	21.3801	23.7259	22.3155	22.4395
230230	22.5346	22.2385	22.3097	22.3587
230232	12.6373	*	*	12.6373
230235	15.9466	16.8684	17.7197	16.8275
230236	23.2178	24.3835	25.9676	24.5556
230239	19.2349	18.0942	17.8168	18.3625
230241	18.8451	19.1000	20.7297	19.5624
230244	21.0758	21.7413	22.2697	21.6892
230253	21.9497	20.5945	21.0433	21.1989
230254	21.2786	21.9402	22.6335	21.9383
230257	20.4721	19.6982	21.3880	20.5021
230259	21.1519	22.2393	22.3969	21.9147
230264	15.1818	17.1319	17.4864	16.5360
230269	22.8138	23.3105	24.0992	23.4229
230270	20.0803	22.6187	22.5985	21.6440
230273	23.4000	22.9199	22.8715	23.0744
230275	17.5975	17.7487	20.8985	18.2554
230276	18.5750	21.3722	25.8709	21.5415
230277	22.5012	23.1456	23.9771	23.2364
230278	16.6645	18.2110	*	17.3814
230279	16.0437	17.6973	17.8074	17.2147
230280	14.2249	15.6654	18.3497	15.8025
230283	*	27.9480	22.5082	24.9202
240001	22.8480	24.6207	25.6936	24.3586
240002	23.0240	22.7981	23.2307	23.0178
240004	23.9195	25.1908	24.4030	24.5010
240005	16.9775	17.9563	20.3193	18.3770
240006	27.1133	25.1602	23.0715	24.9568
240007	16.9802	17.7625	19.0850	17.9138
240008	21.8068	20.2158	23.3783	21.6628
240009	16.6910	16.8965	17.1187	16.9211
240010	23.6323	23.6477	25.4752	24.2587
240011	18.9559	20.5192	21.5875	20.3298
240013	18.9705	20.3282	21.7544	20.2656
240014	21.8560	23.0025	24.2610	23.0452
240016	19.8624	20.4017	22.2011	20.8274
240017	17.2325	18.3585	18.9272	18.1627
240018	19.0671	20.8501	18.4268	19.4219
240019	20.9869	22.1501	23.1477	22.1062
240020	19.5727	21.1937	20.8849	20.5389
240021	17.3968	18.7515	20.1457	18.6569
240022	19.1554	21.7889	21.3234	20.7594
240023	20.3923	21.5087	22.8224	21.4999
240025	17.2464	18.8345	20.0308	18.7384
240027	16.2531	19.1017	16.7758	17.3367
240028	19.3781	19.7918	25.1934	21.5071
240029	17.9880	21.1329	20.0164	19.6781
240030	18.4358	18.8547	20.1653	19.1669
240031	18.0652	18.1566	19.3983	18.5009
240036	20.3270	22.2460	22.1721	21.6421
240037	18.4564	19.2345	20.1195	19.3188
240038	26.3539	25.3061	24.3957	25.3169
240040	19.9022	20.4813	23.1352	21.0482
240041	19.2127	19.2864	21.8655	20.0389
240043	17.3064	17.7335	16.9859	17.3013
240044	18.9217	18.8411	20.3339	19.3394
240045	20.9873	21.1396	24.1557	22.0716
240047	21.8576	22.6152	23.8098	22.7467
240048	23.3110	*	*	23.3110
240049	22.1345	*	*	22.1345
240050	24.5027	25.2983	21.6499	22.6550
240051	18.2287	19.9195	22.5855	20.1307
240052	19.2190	20.7749	*	19.9948

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
240053	21.1987	22.9611	23.8693	22.7802
240056	22.2927	23.4226	23.7139	23.1375
240057	23.2377	24.2159	24.8686	24.1392
240058	14.9141	14.9697	18.4009	15.9713
240059	21.9575	23.6215	23.7808	23.1092
240061	25.5581	27.2603	25.9951	26.2655
240063	23.5426	23.7866	24.4031	23.9101
240064	20.7602	23.2860	22.8578	22.2645
240065	12.5547	12.7867	14.8734	13.4307
240066	22.0542	23.0698	24.1143	23.1023
240069	19.1834	19.8282	21.7991	20.2573
240071	19.1913	20.2101	21.2463	20.2337
240072	18.0015	21.1824	20.9529	20.0007
240073	15.6318	16.0840	17.3559	16.3592
240075	21.1934	21.2654	21.3357	21.2661
240076	21.0702	21.8795	22.3280	21.7859
240077	14.9493	15.3794	20.3445	16.8827
240078	22.7122	23.9150	25.1082	23.9382
240079	17.8206	18.4338	18.8345	18.3648
240080	23.7286	24.3399	25.5619	24.7160
240082	18.0272	18.3555	18.7995	18.3952
240083	19.2922	19.7637	21.0317	20.0094
240084	19.6078	19.4739	21.7421	20.2965
240085	18.0214	22.5736	20.9778	20.5540
240086	15.3302	16.9392	18.1401	16.9654
240087	17.0624	18.8352	21.3323	19.0315
240088	21.0202	21.6858	23.1056	21.8928
240089	18.4171	20.7239	21.1989	20.0227
240090	18.0490	19.2968	19.2166	18.8331
240093	18.6788	18.7092	20.2400	19.2268
240094	20.5705	20.9446	22.0247	21.2053
240096	18.3365	20.1644	21.0417	19.7961
240097	23.6230	24.2662	27.9496	25.1295
240098	20.6036	21.3467	24.2296	22.0643
240099	14.3759	14.4649	15.4964	14.7485
240100	19.1921	20.8302	20.8325	20.3051
240101	17.7478	19.2120	19.9837	18.9205
240102	15.5644	14.6067	16.3659	15.5008
240103	16.8805	19.1540	18.7510	18.2532
240104	24.0175	23.2178	23.5351	23.5902
240105	14.7904	14.3965	*	14.6094
240106	23.7818	23.5148	23.5005	23.6022
240107	19.0299	20.3983	20.9004	20.0558
240108	16.4605	15.3547	18.2427	16.5529
240109	13.1537	13.5537	16.3216	14.2359
240110	17.2834	19.4828	21.0277	19.2199
240111	17.0408	17.2100	17.8617	17.3567
240112	15.3246	15.8350	16.6244	15.9308
240114	15.4919	16.2505	17.3682	16.3794
240115	22.1575	23.7765	23.8675	23.3187
240116	15.1757	16.6731	18.3520	16.6014
240117	17.5676	18.0636	17.9941	17.8845
240119	22.4981	20.6126	21.8289	21.5894
240121	21.3747	23.4018	22.2266	22.3266
240122	18.0396	19.1811	21.2876	19.5090
240123	15.5968	16.5098	18.3941	16.7420
240124	19.0505	19.4400	20.4728	19.6473
240125	13.1505	12.3627	14.9708	13.5694
240127	14.7670	15.8966	17.9724	16.1476
240128	16.0759	17.2513	16.3608	16.5520
240129	15.4226	14.4212	16.5209	15.4258
240130	15.6477	14.9399	16.4271	15.6650
240132	24.4998	23.0669	23.1452	23.5239

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
240133	18.5216	19.2126	19.5293	19.1081
240135	13.6014	14.3069	15.7015	14.4270
240137	19.1770	20.3750	21.5073	20.3195
240138	13.7359	15.2062	16.7332	15.1922
240139	17.0163	20.8053	20.5496	19.6213
240141	21.9909	23.8066	23.1009	22.9648
240142	20.6139	25.2770	29.2238	24.5024
240143	14.2790	16.6172	20.4266	16.9078
240144	15.8710	18.2604	21.4469	18.2664
240145	14.9997	17.2778	19.0689	17.4197
240146	16.7496	16.0652	16.5412	16.4544
240148	11.3388	18.8779	19.5204	16.6060
240150	12.8255	13.8786	20.8331	15.4453
240152	20.2020	21.1678	22.4744	21.2973
240153	15.6079	16.5412	19.3336	17.0363
240154	17.0625	17.5769	21.5052	18.6158
240155	20.4189	19.8762	20.9385	20.4180
240157	14.6914	17.4168	13.7309	15.3007
240160	16.6034	15.9492	15.9014	16.1454
240161	15.4160	15.7996	16.8809	15.9681
240162	19.0404	16.6292	19.1542	18.1964
240163	17.8714	18.8320	20.4760	18.9698
240166	16.3907	17.3233	19.4131	17.7688
240169	18.6155	16.6725	16.3958	17.2174
240170	17.6501	18.8762	20.3779	18.9004
240171	16.7237	17.2886	18.5172	17.5402
240172	16.0711	18.2852	20.8606	18.2323
240173	16.7411	17.2655	18.5187	17.5027
240179	16.6464	17.5116	20.4004	18.1225
240184	14.3996	15.3793	16.8917	15.4746
240187	17.5154	19.9230	21.2736	19.5789
240193	16.3004	17.8226	18.4664	17.4827
240196	23.2666	24.3472	25.3479	24.3358
240200	14.7295	14.3415	14.9076	14.6539
240207	23.3339	24.1127	25.2814	24.2879
240210	23.8391	24.2218	24.5664	24.2274
240211	20.5548	19.7399	30.6260	22.1746
250001	18.1407	18.4233	19.2756	18.6319
250002	15.6036	17.2501	18.6938	17.1218
250003	15.6560	17.6539	16.7570	16.6622
250004	17.1177	17.8868	18.3860	17.7913
250005	12.0032	12.5993	12.5834	12.3909
250006	15.7036	16.9048	17.5192	16.6995
250007	19.1555	19.2913	19.7562	19.3984
250008	13.3179	14.1760	15.8506	14.4224
250009	16.1847	18.5610	17.7283	17.5396
250010	13.3372	13.3905	14.6101	13.7324
250012	18.4756	14.1623	16.7579	16.4800
250015	11.0747	13.5274	11.7249	11.9737
250017	17.3006	17.9410	20.5976	18.5334
250018	13.4707	11.9311	13.1687	12.7895
250019	17.1501	16.7425	18.0956	17.3536
250020	14.0618	13.4476	16.2698	14.4562
250021	9.0772	9.4318	10.5844	9.6552
250023	13.5440	13.9116	12.3434	13.2963
250024	11.5940	12.7127	12.9899	12.4525
250025	17.8890	19.0390	20.3625	19.2022
250027	12.4241	14.9519	14.5445	13.9032
250029	14.8456	16.4834	16.0682	15.8412
250030	13.6277	17.3636	26.6173	19.2750
250031	18.7663	17.9715	18.3825	18.3676
250032	17.2983	17.1339	17.5957	17.3467
250033	15.7646	17.8257	15.0941	16.2509

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
250034	18.1269	16.6988	17.0399	17.2230
250035	17.4148	15.2353	16.8349	16.3942
250036	13.7928	15.8445	16.1913	15.3676
250037	10.3212	15.4325	12.7156	12.4979
250038	13.6207	16.8454	17.7019	16.0182
250039	16.5105	14.1556	15.1409	15.2552
250040	15.6367	17.3430	18.3364	17.1495
250042	16.4728	16.3867	17.6531	16.8406
250043	13.6492	16.0729	16.6500	15.4718
250044	16.7462	16.1218	16.7321	16.5323
250045	19.4788	22.0839	21.8988	21.2480
250047	12.0953	13.3706	14.7461	13.3242
250048	15.7073	16.8932	17.6649	16.7793
250049	10.7578	11.6715	12.1635	11.5642
250050	13.9220	14.3949	15.1159	14.4819
250051	9.6017	9.3464	10.4900	9.8032
250057	14.2863	15.9237	16.1838	15.4582
250058	15.4206	15.5327	15.7197	15.5555
250059	14.2997	16.2845	16.6494	15.7755
250060	7.9882	13.0301	16.1804	11.2768
250061	13.9655	11.0308	11.5108	11.9846
250063	14.9743	13.2540	13.3092	13.7869
250065	12.6803	12.8853	13.6904	13.0682
250066	14.3274	15.6760	16.1742	15.4025
250067	15.2871	16.4120	16.8522	16.2039
250068	11.4272	13.6768	13.4127	12.8087
250069	15.7653	17.8960	16.8980	16.8834
250071	11.2079	14.3781	12.3488	12.5425
250072	16.9263	18.2218	18.9487	18.0776
250076	*	10.5098	*	10.5098
250077	11.4135	12.2564	13.7404	12.5026
250078	15.4571	15.6336	15.9739	15.6895
250079	19.0587	16.2712	16.5835	17.1998
250081	16.1412	17.3325	19.0358	17.4600
250082	14.0249	16.0975	17.1427	15.7611
250083	9.2019	14.2634	16.6065	13.1746
250084	19.7390	17.0189	20.6429	19.0165
250085	13.8487	14.3797	15.4477	14.5716
250088	16.7514	17.8674	18.2736	17.6409
250089	13.0481	13.4238	14.3027	13.5884
250093	15.0918	15.2044	16.1506	15.4926
250094	17.8539	18.0852	18.5063	18.1422
250095	16.3574	17.0039	17.4217	16.9079
250096	17.0713	19.0688	19.0584	18.3546
250097	18.4099	16.9905	15.5741	16.9320
250098	14.3017	13.1341	18.3874	15.0909
250099	14.4142	14.8528	15.1265	14.8018
250100	16.6033	17.1682	17.8688	17.2128
250101	16.3083	18.4685	17.7194	17.5079
250102	20.0190	23.9329	18.9348	20.8793
250104	17.5421	18.2502	18.7651	18.1832
250105	14.5986	14.5401	15.5133	14.8921
250107	13.6296	15.1496	15.0737	14.6455
250109	14.5496	22.1551	21.3867	18.8951
250112	14.2023	15.5610	16.3640	15.3179
250117	14.5171	16.1225	16.9787	15.9014
250119	12.7379	15.2199	16.1218	14.6728
250120	14.4126	15.3433	16.7182	15.4420
250122	17.7079	18.9417	19.2990	18.6619
250123	17.4068	18.8690	18.7863	18.3698
250124	12.6677	13.1823	13.2490	13.0310
250125	14.4867	20.8895	21.2660	18.4338
250126	14.7083	18.2355	21.9101	17.8900

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
250128	12.9968	14.0048	16.1418	14.4375
250131	10.2765	12.6056	12.4557	11.6657
250134	17.9755	17.0671	18.5142	17.8554
250136	18.0538	18.9689	21.3497	19.3579
250138	17.5999	18.4028	20.4550	18.6918
250141	17.1247	19.0113	19.6692	18.6505
250145	11.4047	10.2507	11.2120	10.9506
250146	13.2763	14.4924	14.7781	14.1955
250148	14.8234	18.0980	19.4233	17.4956
250149	12.9840	12.9569	15.2318	13.7102
250150	*	*	21.8599	21.8599
260001	17.5520	18.0971	20.1560	18.5941
260002	20.5878	22.1183	21.6597	21.4585
260003	14.3537	14.6553	15.4482	14.8108
260004	13.7528	13.0133	13.7035	13.4793
260005	19.7058	19.5554	23.9681	21.0036
260006	18.9408	19.7467	20.0994	19.6144
260008	16.2451	13.8495	16.8893	15.5719
260009	17.9364	18.5080	18.2863	18.2469
260011	18.3378	19.1027	19.5059	18.9819
260012	14.4594	14.3645	17.1662	15.3316
260013	15.5388	15.9884	16.1825	15.8932
260015	21.3327	16.5822	17.8817	18.4578
260017	15.8013	16.7916	16.9914	16.5434
260018	12.2293	12.0060	12.5301	12.2688
260019	23.6727	18.6113	*	20.6992
260020	21.8585	20.5142	20.2241	20.8205
260021	17.5694	22.1017	21.6237	20.1803
260022	19.3454	17.2462	17.7772	17.8898
260023	15.8235	16.4705	17.8649	16.6827
260024	13.4737	15.2356	15.7815	14.8371
260025	14.9377	15.4935	17.0965	15.8836
260027	21.0084	21.2977	22.0362	21.4252
260029	17.4744	19.7484	21.1858	19.3784
260030	11.2434	12.5118	11.9215	11.8847
260031	18.3039	19.4921	19.7249	19.1438
260032	20.8097	20.1988	19.6728	20.2222
260034	17.8986	17.4233	20.4902	18.5746
260035	12.5886	13.1065	13.0071	12.9052
260036	18.3128	16.7430	18.8104	17.9282
260039	14.1980	14.1866	14.6644	14.3527
260040	15.3853	17.3099	18.0140	16.9033
260042	17.4459	18.7567	18.7514	18.2697
260044	17.1177	15.9927	15.9206	16.3491
260047	17.2768	19.0112	19.2247	18.5386
260048	21.4309	20.0885	21.0602	20.8622
260050	18.7366	15.6908	16.8520	17.0991
260052	17.7502	18.0553	18.0914	17.9657
260053	12.0098	15.2236	16.5166	14.4005
260054	17.3708	20.0199	20.6242	19.2873
260055	13.7961	12.0118	15.4214	13.6790
260057	15.3276	17.4636	19.7144	17.7259
260059	15.7887	16.1000	17.0546	16.3478
260061	15.0099	14.7175	15.7112	15.1405
260062	20.2655	20.1477	21.3138	20.5946
260063	16.8474	18.2309	18.8973	17.9893
260064	16.5033	16.5934	17.8033	16.9429
260065	18.4654	19.4382	20.0975	19.3238
260066	14.4163	14.9640	15.3460	14.8934
260067	12.1588	14.2249	15.1837	13.8617
260068	19.8261	20.2418	19.4240	19.8242
260070	21.6873	*	13.9510	17.3672
260073	13.0075	14.2550	15.9182	14.4333

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
260074	15.4480	19.0350	19.8915	18.1123
260077	18.2594	18.6473	19.4482	18.8035
260078	15.4754	15.6381	14.9463	15.3700
260079	14.8281	14.2985	16.1453	15.0169
260080	12.5631	13.5384	14.6832	13.5392
260081	18.9629	21.0151	20.3053	20.0653
260082	15.7880	15.9407	15.9858	15.9090
260085	19.5153	20.4669	20.7051	20.2110
260086	14.8730	14.3164	15.2927	14.8291
260091	19.6081	19.9987	21.5464	20.5925
260094	15.8705	18.0085	18.5395	17.5281
260095	19.7672	19.6944	20.7292	20.0618
260096	21.7176	23.0282	22.5972	22.4661
260097	15.7899	16.5582	19.0632	17.1704
260100	15.7324	15.7047	16.6523	16.0345
260102	16.3653	20.1264	20.6361	18.8983
260103	17.3541	18.5957	19.7146	18.4987
260104	19.1158	21.0138	20.3176	20.0928
260105	20.8006	24.7223	24.8181	23.3052
260107	18.4618	19.8422	20.4269	19.5069
260108	19.2422	19.4609	20.0034	19.5906
260109	13.4400	13.9129	14.8181	14.0725
260110	16.9952	17.8375	18.3227	17.7209
260113	14.8968	14.6756	16.2223	15.2316
260115	17.8971	19.2259	17.4698	18.2033
260116	14.5715	16.2774	14.9812	15.2548
260119	16.2000	16.8836	17.2942	16.7641
260120	17.1269	16.3755	16.4904	16.6414
260122	14.5390	14.9697	16.0931	15.2238
260123	13.9960	14.6444	14.6822	14.4496
260127	15.9481	18.3572	18.4026	17.5109
260128	11.2705	13.0481	12.6414	12.2813
260129	14.6353	*	*	14.6353
260131	19.7491	17.7686	18.4154	18.5978
260134	16.5834	16.2832	17.5127	16.7877
260137	15.2169	17.9531	19.4697	17.5188
260138	21.3885	22.6491	23.2364	22.4440
260141	17.9598	19.1580	19.1893	18.7555
260142	16.0299	17.1248	17.3084	16.7937
260143	11.9389	12.7867	13.9040	12.7859
260147	13.6568	14.0778	14.7769	14.1672
260148	10.3383	11.8674	11.3524	11.2072
260158	12.4020	12.3005	12.7699	12.4966
260159	18.2232	20.3177	19.7951	19.3893
260160	16.1922	15.8394	16.5792	16.2009
260162	20.7103	19.5655	21.4099	20.5728
260163	14.8051	16.4245	15.8593	15.6940
260164	14.3089	14.9372	15.1211	14.8191
260166	19.5343	20.1025	21.1224	20.2675
260172	12.4851	15.4163	16.0772	14.6285
260173	11.9777	12.8523	14.2090	13.1471
260175	16.2940	16.9023	17.5625	16.9246
260176	19.5449	26.8712	21.6044	22.7500
260177	20.7457	21.2578	21.9014	21.3180
260178	21.4080	19.6638	20.2796	20.4480
260179	20.7397	21.4906	22.7185	21.6624
260180	18.5398	19.5819	18.9881	19.0361
260183	20.1940	20.0712	21.3175	20.5306
260186	18.0588	19.3238	19.6026	19.0698
260188	18.5772	20.6388	22.5060	20.5016
260189	10.7518	11.3004	16.4233	12.7425
260190	18.1639	18.5168	19.3419	18.6978
260191	19.3386	17.9812	18.1604	18.4767

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
260193	20.5055	21.1588	20.2577	20.6284
260195	15.9518	17.7237	19.7068	17.8042
260197	16.4605	19.2840	20.5453	18.3884
260198	17.6381	11.9751	19.7552	15.6949
260200	18.8755	20.5339	20.6888	20.0233
260205	*	17.6210	*	17.6210
270002	17.1866	28.9959	19.2387	20.5385
270003	22.1299	22.0995	22.5019	22.2424
270004	21.3442	19.6292	19.4834	20.1660
270006	16.1872	16.0238	17.0715	16.3653
270007	13.1679	11.3143	13.8824	12.6774
270009	17.7016	17.2292	20.8238	18.5056
270011	19.8229	20.2669	21.1653	20.3748
270012	22.8770	19.7346	19.7878	20.8557
270013	20.4012	*	*	20.4012
270014	18.5595	19.0872	19.9859	19.2205
270016	19.7675	19.6717	18.6149	19.4350
270017	19.5798	21.0800	20.0152	20.2382
270019	12.7812	18.1099	15.4128	15.4635
270021	16.6541	17.1787	16.9457	16.9258
270023	20.3641	22.2639	22.7181	21.7139
270026	15.6381	17.5102	18.0568	17.0775
270027	9.7758	13.1392	17.2091	12.8885
270028	17.2132	21.1492	19.1177	19.1160
270029	17.8852	16.5666	17.3710	17.2639
270032	17.0285	17.7393	18.7811	17.8749
270033	16.4554	16.9602	18.4876	17.2764
270035	17.6482	16.8295	16.4302	16.9974
270036	14.0815	14.2537	16.8552	14.8821
270039	15.3501	15.9368	19.6796	16.7774
270040	19.1901	18.8145	20.1242	19.3585
270041	16.7791	19.0327	25.8153	19.7981
270044	13.4559	16.7710	17.5137	15.8620
270046	17.1048	*	*	17.1048
270048	15.8403	17.0154	18.0666	16.8972
270049	21.1670	22.2444	22.2540	21.8899
270050	18.0448	16.7110	19.9356	18.1546
270051	18.9468	20.2735	20.1950	19.8100
270052	14.8042	14.4773	14.7009	14.6552
270057	20.0080	21.1317	20.6714	20.6119
270058	14.0669	14.7481	16.1412	14.9510
270059	15.5957	14.7530	19.1808	16.3576
270060	14.0212	15.2727	20.4148	16.5316
270063	14.2287	12.6108	15.1049	13.8837
270073	15.5281	14.4569	16.1937	15.3359
270079	15.0277	15.6873	16.7048	15.7603
270080	14.0437	16.3171	15.0705	15.0926
270081	15.5207	15.6262	16.7389	15.9424
270082	16.1280	17.3443	23.1245	18.7794
270083	20.8231	18.4432	17.8554	18.9597
270084	16.2075	16.6243	16.2958	16.3734
280001	17.8928	17.3541	18.1831	17.7825
280003	21.9957	22.3179	23.0213	22.4564
280005	18.7477	19.2405	23.6949	20.6104
280009	18.7541	19.8145	20.9643	19.8453
280010	16.5417	17.4859	20.0462	17.5272
280011	13.9627	15.8573	15.9614	15.3328
280012	16.4079	*	*	16.4079
280013	22.1767	22.8063	22.5163	22.5039
280014	15.2414	15.9596	16.8368	15.9667
280015	14.6353	17.0281	16.6939	16.1405
280017	14.1897	14.2059	13.9939	14.1278
280018	14.8492	15.1328	15.4496	15.1512

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
280020	19.3963	19.9667	21.2467	20.2637
280021	16.6949	17.1048	17.6345	17.1389
280022	15.7059	16.7179	16.8184	16.3693
280023	21.2387	25.8494	22.3433	23.0540
280024	13.9115	14.2186	15.0380	14.3613
280025	14.2701	15.5850	21.4764	16.6875
280026	16.0599	16.6861	16.5851	16.4520
280028	15.8871	17.3176	18.0793	17.1201
280029	19.0519	23.1292	24.4359	21.9196
280030	28.7091	24.5366	24.7723	25.8891
280031	13.2242	13.5654	9.6321	12.1542
280032	19.3884	18.8964	19.1191	19.1301
280033	14.9334	15.7583	17.4745	16.1329
280034	15.2821	*	*	15.2821
280035	15.3304	15.9170	16.6872	15.8969
280037	16.1684	16.7952	17.1064	16.6926
280038	16.4685	17.0878	18.2503	17.2635
280039	15.1916	16.0442	16.1587	15.8239
280040	18.9717	19.5333	20.9896	19.8846
280041	13.3901	16.4083	16.5503	15.4920
280042	15.3029	16.1191	16.6239	16.0122
280043	15.7858	16.6570	17.5937	16.7160
280045	14.2741	16.9048	15.7630	15.6286
280046	13.7155	17.9221	17.3214	16.1724
280047	18.3743	18.3407	17.4735	18.0424
280048	14.0702	15.8723	15.8100	15.1939
280049	15.6343	18.3605	18.4365	17.4677
280050	15.3413	16.6432	20.0379	17.6064
280051	15.8504	15.6336	17.1942	16.1502
280052	13.6489	14.0819	14.1201	13.9629
280054	17.5819	18.7992	18.7575	18.3765
280055	12.9933	13.5667	13.8129	13.4587
280056	14.0151	12.6475	15.6135	14.0018
280057	15.7623	18.0454	20.0686	17.7576
280058	17.8798	19.6752	21.4868	19.6876
280060	28.6047	19.7527	20.7022	22.2434
280061	17.9511	17.1629	18.6370	17.9240
280062	13.6738	14.4896	15.6018	14.6170
280064	15.5092	16.2977	16.8330	16.2046
280065	18.5327	19.2932	20.7370	19.5513
280066	11.6416	11.6621	11.7207	11.6766
280068	10.1327	9.4943	10.5987	10.0463
280070	13.7353	17.7400	22.6201	17.5276
280073	17.0583	17.4244	17.7698	17.4266
280074	15.2182	16.4310	17.3143	16.2521
280075	13.7875	15.5327	13.2230	14.1041
280076	13.9203	14.8469	16.7488	15.0947
280077	19.0145	19.2068	20.0148	19.4096
280079	9.9132	10.4540	16.6117	11.4307
280080	14.3528	15.3308	16.9487	15.6285
280081	20.9196	21.0771	20.9606	20.9873
280082	13.1250	14.3399	14.6173	14.0723
280083	17.5544	18.2992	21.5336	19.2134
280084	11.6868	12.5836	13.6536	12.6157
280085	21.5793	20.4302	20.4825	20.9817
280088	22.1147	20.2961	*	21.2560
280089	17.4696	18.1668	18.9567	18.1923
280090	14.7191	14.1362	15.1274	14.6962
280091	15.2184	15.8436	16.1866	15.7538
280092	14.1998	14.1945	14.7912	14.4303
280094	15.8843	17.6873	16.3474	16.6450
280097	14.2990	14.1734	13.8223	14.0824
280098	10.1686	13.0029	12.5875	12.0141

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
280101	17.4168	13.5261	16.9973	15.7528
280102	12.9367	14.0102	*	13.4735
280104	13.3842	13.2819	16.2167	14.1456
280105	18.7851	18.6575	21.0735	19.5325
280106	15.5396	16.1247	16.0679	15.9189
280107	13.4553	13.3311	14.4679	13.7065
280108	17.2185	17.5625	17.1961	17.3277
280109	11.0622	12.6803	12.4408	12.0678
280110	12.2950	12.7546	14.2136	13.0914
280111	23.0856	21.8773	19.6283	21.4131
280114	13.5580	15.7160	17.3076	15.4628
280115	16.4282	16.7041	18.1480	17.1049
280117	16.8216	17.7276	18.8279	17.8057
280118	16.9228	16.8687	18.6524	17.4822
280123	20.7732	14.0637	11.8582	15.0281
280125	*	16.1332	16.3944	16.2644
290001	22.4188	22.8226	22.7450	22.6608
290002	20.9442	17.2554	16.5419	18.3712
290003	25.0066	22.8840	24.2175	23.9864
290005	17.8609	19.4888	21.9814	19.6686
290006	19.8815	21.8070	22.4063	21.4371
290007	29.6864	29.7706	30.9075	30.1389
290008	20.2506	20.6190	24.1255	21.5150
290009	22.7399	23.3620	23.9373	23.3345
290010	14.4800	15.6423	16.4476	15.5219
290011	16.4419	20.1564	21.1234	19.0261
290012	21.5139	21.8275	25.0430	22.8581
290013	17.0883	18.2713	15.7932	17.0224
290014	18.3755	18.9743	18.7829	18.7144
290015	17.8303	22.3487	19.4504	19.7229
290016	12.7869	14.3542	23.8656	16.2244
290019	20.9336	21.2509	22.2045	21.4895
290020	26.1502	20.8733	21.2380	22.7207
290021	21.1250	21.5806	22.9488	21.8726
290022	24.0856	24.5468	25.5011	24.7398
290027	16.4289	16.7786	13.3769	15.4098
290032	22.7882	22.8447	23.9504	23.1730
290036	18.6112	*	12.9074	15.9259
290038	23.1402	20.6753	27.7030	22.6435
290039	25.8004	25.3864	25.5024	25.5429
290041	*	*	25.9905	25.9905
290042	*	*	18.7527	18.7527
290043	*	*	27.9053	27.9053
300001	21.4192	22.0909	23.8567	22.4761
300003	23.3777	22.9111	24.1297	23.4634
300005	19.9876	20.7545	22.2858	20.9804
300006	18.9331	23.7793	18.9745	20.5179
300007	19.3447	20.2372	20.6325	20.0620
300008	16.4649	20.7702	19.6149	18.9666
300009	20.0057	18.0602	20.0938	19.3221
300010	19.3833	19.3940	20.2130	19.6671
300011	21.2429	22.4325	23.0279	22.1850
300012	23.8859	24.5673	24.5619	24.3251
300013	18.9664	19.1247	20.1669	19.4250
300014	19.7969	20.3292	20.1774	20.0987
300015	19.9308	20.4916	19.6627	20.0406
300016	18.5037	21.8659	17.8148	19.4173
300017	22.3408	21.6563	22.7191	22.2414
300018	20.8947	21.2381	21.6385	21.2565
300019	20.6090	20.9753	19.6728	20.4155
300020	21.9725	21.9165	22.6627	22.2032
300021	17.3477	18.6211	19.3101	18.4253
300022	17.1864	18.3507	19.1875	18.2148

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
300023	20.3909	22.1210	22.7649	21.7833
300024	17.9460	19.9116	21.5842	19.6334
300028	18.0515	17.4075	20.0778	18.5816
300029	20.8961	22.5748	22.6013	22.0065
300033	19.8506	17.1869	17.1632	17.9333
300034	23.5215	25.5182	24.4975	24.5048
310001	27.5967	28.1329	27.4730	27.7287
310002	27.8735	28.3434	27.9728	28.0592
310003	27.4152	29.1096	27.5624	28.0099
310005	23.0493	22.1146	22.9712	22.6992
310006	21.5557	21.5957	22.0894	21.7417
310008	24.9483	23.5084	24.7618	24.4065
310009	23.1906	23.6371	21.7094	22.8601
310010	21.1064	22.5682	23.1060	22.2131
310011	23.4038	23.1977	24.2885	23.6223
310012	26.3249	26.5242	26.6772	26.5118
310013	22.1062	21.2251	22.5603	21.9726
310014	28.6964	27.4614	23.1956	26.3647
310015	26.7584	27.4331	27.9684	27.3934
310016	26.0518	24.3838	24.5206	24.9705
310017	26.0703	25.7902	24.5976	25.5018
310018	24.5312	22.8428	22.4779	23.3087
310019	23.0888	24.0542	24.9914	24.0619
310020	19.2663	24.1848	24.4152	22.3484
310021	22.6456	23.9369	25.4393	23.9309
310022	20.7276	21.2706	20.8258	20.9386
310024	22.7831	24.2353	24.9521	23.9428
310025	22.8129	24.3513	24.1812	23.7695
310026	23.8726	23.5491	22.1997	23.2228
310027	21.7666	21.8846	22.5696	22.0722
310028	23.5188	23.4577	23.9428	23.6444
310029	23.3801	22.6629	23.6610	23.2308
310031	25.1780	26.1567	26.6831	25.9979
310032	23.3017	24.3528	24.7404	24.1425
310034	21.6851	23.2729	24.1150	22.9962
310036	19.8178	20.1905	21.7187	20.5557
310037	27.4447	27.7823	28.1289	27.7758
310038	25.3832	26.7209	28.4893	26.9013
310039	22.0259	22.1754	22.7317	22.2988
310040	23.9864	26.1492	26.3573	25.4478
310041	23.7829	24.8960	23.5559	24.0709
310042	24.3292	23.2472	24.7678	24.1098
310043	22.0887	21.9022	21.6128	21.8925
310044	20.4309	21.6677	23.1549	21.6891
310045	28.1570	28.4854	28.9274	28.5212
310047	24.5225	25.1101	26.1921	25.2615
310048	23.3295	23.6118	25.2870	24.0821
310049	24.7617	24.8299	27.0842	25.4915
310050	22.5877	25.1752	24.7988	24.2032
310051	25.2762	27.1265	27.5378	26.5967
310052	22.5753	22.9326	23.3973	22.9809
310054	24.7413	26.1726	27.7376	26.1388
310057	20.4484	21.1686	22.2572	21.2802
310058	26.2243	26.5308	26.3765	26.3747
310060	19.1119	19.1992	20.0997	19.4729
310061	20.8023	23.2646	33.9582	25.0082
310062	19.2729	22.9073	*	21.3672
310063	21.8540	21.9045	22.1080	21.9521
310064	24.2115	24.8567	25.4822	24.8391
310067	22.2740	25.0888	23.9278	23.7333
310069	24.1662	23.7531	24.2329	24.0530
310070	25.0448	26.0903	28.2220	26.3630
310072	22.2231	21.7605	22.5611	22.1704

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
310073	25.6299	28.5149	26.2937	26.7849
310074	24.4638	23.8340	22.3588	23.6496
310075	26.4606	23.3266	24.4788	24.7522
310076	28.8981	30.0797	27.9918	29.0283
310077	25.0569	25.2500	26.1251	25.4460
310078	23.4788	23.8841	24.0587	23.7967
310081	23.8898	22.0762	22.4086	22.8084
310083	23.6761	23.8852	24.8204	24.1353
310084	24.0915	26.6753	24.6049	25.1157
310086	21.4350	22.1674	23.1719	22.2404
310087	20.8875	20.7243	21.1215	20.9125
310088	22.3419	22.3160	23.1722	22.6064
310090	24.2426	23.8284	24.8986	24.3109
310091	22.0103	22.7978	23.2969	22.6743
310092	22.3446	20.5165	21.6964	21.5200
310093	21.2302	22.4291	23.7251	22.4166
310096	26.3041	25.1572	24.5759	25.3591
310105	24.4851	25.5891	26.2537	25.4282
310108	22.8801	22.4756	23.8308	23.0488
310110	20.1400	21.8341	23.2146	21.7904
310111	21.7218	1.1066	22.1151	21.6430
310112	22.5213	23.6701	24.7914	23.6656
310113	22.9536	23.6841	23.1961	23.2803
310115	20.0667	21.7320	21.1645	20.9731
310116	25.2429	22.9812	23.6366	23.9253
310118	24.5443	26.4625	26.1315	25.6352
310119	29.4809	33.6686	32.7858	31.9394
310120	21.6852	23.9681	23.3200	22.9127
310121	18.7365	*	*	18.7365
320001	17.8522	19.1150	20.6225	19.1818
320002	22.4623	22.6175	23.0983	22.7062
320003	15.3484	15.9504	16.4642	15.9014
320004	17.2353	18.5824	19.6642	18.5890
320005	19.8698	21.6103	21.0411	20.8577
320006	18.6472	18.9019	20.3863	19.2674
320009	17.6400	18.2883	19.3500	18.4218
320011	16.5481	20.0601	18.5222	18.4330
320012	15.9972	16.4355	17.1764	16.5374
320013	23.8390	22.9573	24.5543	23.8179
320014	15.9666	16.3598	16.8412	16.4003
320016	18.9296	20.5398	18.8519	19.4293
320017	18.1545	18.6388	19.4498	18.7392
320018	18.1944	18.8479	19.2336	18.7690
320019	19.2600	24.4707	26.9637	23.5577
320021	17.1647	17.8705	19.0457	17.9920
320022	15.8391	16.1777	18.0606	16.7167
320023	16.4170	18.0548	17.8419	17.3761
320030	16.5266	16.5495	18.6859	17.1956
320031	13.9914	19.6768	25.1715	19.2605
320032	18.7536	18.8097	20.6871	19.3668
320033	20.3137	25.0777	21.0621	21.9427
320035	25.7392	21.5186	15.0612	19.2882
320037	17.0846	17.0305	17.8280	17.3203
320038	16.2896	16.8117	22.2664	18.6619
320046	19.0033	18.3190	18.9607	18.7526
320048	19.1705	19.9642	16.8769	18.5918
320063	19.8320	18.3237	17.9089	18.6049
320065	16.1046	16.7933	18.6525	17.1721
320067	57.4818	33.8654	15.3228	25.9798
320068	18.1809	17.4785	18.5103	18.1180
320069	11.3058	13.0094	14.4212	12.8497
320074	18.6545	19.3406	20.2290	19.3600
320079	17.0696	18.2828	19.8555	18.3645

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
330001	25.2067	26.5533	27.3996	26.4208
330002	26.3926	26.5370	26.9341	26.6121
330003	18.0549	19.4102	18.9211	18.7797
330004	19.9573	22.5298	20.9501	21.1368
330005	24.2795	24.8338	22.1957	23.2739
330006	25.9186	25.0576	25.8006	25.5856
330007	18.7956	18.9024	*	18.8475
330008	18.0684	19.0045	19.2341	18.7497
330009	30.4220	30.6918	31.3435	30.8056
330010	14.7382	17.4512	16.6508	16.1432
330011	18.0419	18.2986	18.6748	18.3483
330012	31.5135	32.7624	*	32.1317
330013	19.9929	19.0856	19.6269	19.5703
330014	27.5704	32.3370	36.8669	32.2778
330016	17.4069	16.9717	16.8016	17.0572
330019	32.4515	35.9822	33.5369	34.0043
330020	14.5488	15.5527	15.1142	15.0641
330023	24.2708	24.4006	25.6512	24.7835
330024	33.6175	34.1682	37.3316	34.9189
330025	16.0290	16.2033	16.8687	16.3599
330027	32.4959	33.4738	35.5255	33.7629
330028	27.0752	28.2089	29.5294	28.2349
330029	16.5552	18.1567	17.0016	17.2536
330030	15.0551	17.4977	19.1085	16.8779
330033	16.7497	18.5353	17.4444	17.6068
330034	30.7840	31.3997	27.7738	30.5701
330036	24.3239	23.9874	25.2820	24.5370
330037	16.0026	16.1140	16.4866	16.2081
330038	16.0153	16.2549	17.3429	16.5336
330039	12.4666	*	*	12.4666
330041	30.4192	24.5215	31.4871	28.4761
330043	27.6286	28.7467	27.4661	27.9537
330044	18.6969	20.0238	19.5219	19.4106
330045	27.1759	28.0758	27.9919	27.7401
330046	31.9802	32.4189	35.2703	33.1562
330047	17.6895	18.1815	18.5536	18.1416
330048	17.6239	17.8787	19.1093	18.1878
330049	19.3136	19.4993	20.5731	19.7930
330053	15.6659	17.4430	17.8082	16.9823
330055	30.7330	36.1109	32.8910	33.1680
330056	30.2206	30.4525	30.0945	30.2540
330057	18.6891	18.7478	19.3643	18.9410
330058	16.9805	17.0014	17.7672	17.2379
330059	32.2285	34.1705	34.2426	33.4744
330061	25.0674	25.7331	25.4082	25.4024
330062	15.2819	17.6067	18.1318	16.9856
330064	32.8724	33.1269	33.6447	33.2084
330065	18.3686	19.8940	19.9305	19.3468
330066	19.9455	19.5611	18.8707	19.4674
330067	21.2872	20.9443	22.1065	21.4528
330072	29.3096	30.8019	30.4171	30.1659
330073	15.8849	16.2898	16.4518	16.2013
330074	18.1636	18.0005	17.7308	17.9678
330075	17.4266	17.2298	17.6385	17.4324
330078	17.4863	16.7949	18.7884	17.6577
330079	16.7608	17.4555	18.7622	17.6535
330080	26.8766	29.2686	31.4424	29.0970
330084	23.0327	18.0435	19.3216	19.8703
330085	18.7835	20.2926	20.6203	19.8951
330086	30.6954	31.2980	23.6496	28.6407
330088	25.6160	25.6626	25.7940	25.6905
330090	18.6833	19.3954	19.2112	19.0937
330091	18.5334	19.0953	19.7776	19.1249

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
330092	12.6540	14.0671	13.3723	13.3059
330094	17.7196	17.5585	18.1582	17.8207
330095	18.5502	20.1073	21.1096	19.8197
330096	16.5963	17.9641	18.5149	17.6975
330097	16.9626	16.2169	16.4433	16.5145
330100	28.1060	27.0661	29.0916	28.0415
330101	31.3075	32.4105	31.5914	31.7153
330102	17.5230	17.5755	19.0058	18.0012
330103	16.5212	15.7197	16.8110	16.3435
330104	28.7669	31.6471	31.2074	30.5068
330106	35.8740	40.2686	35.3775	37.0516
330107	28.0780	28.5580	27.7797	28.1411
330108	17.0846	17.3605	18.0786	17.5050
330111	15.2047	19.5314	15.9321	16.7001
330114	18.2390	17.3522	17.0581	17.5626
330115	16.5581	17.4430	17.4684	17.1455
330116	24.2266	24.4622	14.9610	20.6732
330118	20.7550	20.6936	*	20.7240
330119	34.7478	34.8385	33.1179	34.2290
330121	15.8468	16.1052	16.3385	16.0964
330122	21.2021	20.8204	20.2417	20.7389
330125	19.7456	19.8494	19.7638	19.7865
330126	22.6990	23.7938	23.8957	23.4789
330127	29.3317	31.9046	30.7356	30.6271
330128	27.8693	29.0222	30.8242	29.1534
330132	14.7006	15.7633	14.3673	14.9673
330133	32.3812	37.2494	35.3576	34.8196
330135	18.3346	18.7120	22.2670	19.6717
330136	17.6041	18.2422	20.1043	18.6252
330140	19.5016	19.1438	19.3615	19.3334
330141	25.1371	26.4956	26.7096	26.0966
330144	15.5068	14.0566	16.2517	15.2343
330148	15.0400	16.8151	16.2782	16.0197
330151	13.9700	16.0714	15.7594	15.2313
330152	29.4818	30.5409	30.8314	30.2117
330153	17.4996	18.9689	18.1776	18.1944
330157	20.8239	22.0792	22.3804	21.7687
330158	26.0476	25.7569	27.1228	26.3184
330159	18.0211	19.1536	19.4998	18.8640
330160	30.5678	32.7840	29.5885	30.9340
330162	27.7162	27.1166	27.6010	27.4784
330163	20.4555	18.7816	20.7456	19.9795
330164	19.4831	19.8647	20.9003	20.0827
330166	14.1815	15.0954	15.4420	14.8722
330167	31.1834	29.3634	30.2346	30.2561
330169	33.4462	37.2655	35.4794	35.3665
330171	25.4314	25.5307	24.8035	25.2597
330175	16.6851	17.3290	18.3116	17.4443
330177	14.5378	17.2907	16.3704	16.0830
330179	12.6857	13.4999	13.8953	13.3684
330180	15.5304	16.8787	17.9877	16.7426
330181	32.4718	32.5192	33.0908	32.6900
330182	30.9260	32.9371	33.6531	32.5479
330183	19.9964	19.9207	20.6164	20.1809
330184	27.4859	30.0400	31.3706	29.6316
330185	26.9496	25.6112	26.8612	26.4537
330188	18.7208	20.9587	18.8000	19.4696
330189	17.6585	15.1253	18.4498	16.9610
330191	18.8586	18.6206	19.0348	18.8384
330193	29.8042	36.5481	30.2260	31.8162
330194	35.5748	34.6785	35.2036	35.1664
330195	31.3915	33.3254	34.8966	33.0747
330196	28.4465	30.8165	30.5799	29.9142

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
330197	16.9990	17.6646	18.3527	17.6922
330198	23.8113	24.6038	24.8590	24.4203
330199	27.6605	28.7609	30.5409	28.9499
330201	30.3293	32.1149	28.7861	30.4144
330202	30.7869	31.4435	31.2575	31.1487
330203	19.2353	20.7575	25.0345	21.5038
330204	29.3662	29.4418	32.2005	30.2707
330205	19.4642	20.5793	22.3490	20.7832
330208	25.8201	26.1822	26.6682	26.2220
330209	24.8834	23.9924	25.1281	24.6749
330211	19.0968	19.5064	19.5405	19.3836
330212	21.1777	21.7705	24.7681	22.5597
330213	18.5066	18.7722	19.6796	18.9552
330214	32.1966	36.4447	32.4292	33.4440
330215	17.5818	19.6926	17.9863	18.3902
330218	21.7072	21.4796	21.1890	21.4557
330219	22.1476	23.9908	23.4310	23.1411
330221	32.2081	27.8485	33.3796	31.2840
330222	17.8140	18.3666	18.5571	18.2482
330223	17.2754	17.6199	17.8306	17.5845
330224	21.9728	19.6410	20.4309	20.7047
330225	25.8043	25.5823	27.0379	26.0910
330226	17.6708	16.6711	23.1859	18.8241
330229	16.2509	16.8026	17.5326	16.8453
330230	28.8625	29.7626	29.6283	29.3810
330231	29.0917	30.0923	32.7200	30.4677
330232	19.5042	17.9083	19.1787	18.8569
330233	33.3008	30.9241	44.1265	35.0751
330234	33.3286	35.1777	35.0720	34.4830
330235	19.4532	21.0842	19.5880	20.0417
330236	30.7017	29.5913	31.3463	30.5397
330238	14.7951	15.6245	17.3976	15.9047
330239	17.2808	17.4462	18.5079	17.7328
330240	30.4765	29.7082	30.7321	30.2841
330241	22.6046	24.6076	23.8638	23.6409
330242	24.7401	28.2612	27.6384	26.8305
330245	17.2803	17.6767	18.5161	17.8488
330246	26.6587	28.1090	28.1205	27.6612
330247	27.6203	28.5310	27.3937	27.8277
330249	16.4818	16.2687	17.1320	16.6304
330250	19.5553	19.5823	19.9619	19.7058
330252	17.0379	*	*	17.0379
330254	16.7252	18.4057	15.9123	17.0146
330258	30.4656	29.7426	31.8910	30.6921
330259	25.2526	26.2661	25.9994	25.8364
330261	26.1654	25.7244	27.9766	26.6137
330263	19.6388	20.4149	18.7378	19.6517
330264	23.1359	22.8672	22.8099	22.9301
330265	15.6249	18.0193	17.6301	17.0414
330267	23.5561	24.5183	24.5939	24.2287
330268	14.6249	13.0595	15.9060	14.5364
330270	28.2392	34.4254	36.0824	32.6382
330273	25.8910	23.1511	26.0565	24.9430
330275	17.4223	19.0548	18.7268	18.3387
330276	17.7452	18.2870	19.0228	18.3342
330277	17.1570	18.3169	19.1761	18.2131
330279	19.9079	19.5983	20.7107	20.0436
330285	22.4717	23.5264	24.0491	23.3509
330286	25.0948	26.7633	27.7762	26.5916
330290	32.5792	33.5056	30.4706	32.2470
330293	15.3782	16.2158	16.9238	16.1248
330304	29.3687	26.7683	27.3562	27.8227
330306	27.6214	27.3798	29.5937	28.1525

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
330307	20.7362	21.0673	21.7257	21.1725
330308	36.8361	*	*	36.8361
330314	24.7399	24.5444	25.9937	25.0514
330316	28.7872	27.6102	27.9543	28.1177
330327	16.9724	16.4611	20.3874	17.9258
330331	31.0405	31.6216	33.1276	32.0298
330332	27.1554	27.6914	25.3689	26.7855
330333	*	29.1931	*	29.1931
330336	30.1708	29.7689	29.8294	29.9290
330338	23.0077	22.4581	21.2670	22.2755
330339	19.6730	20.0111	20.1028	19.9220
330340	26.9201	28.8419	28.4129	28.0687
330350	30.3754	30.8889	30.9763	30.7427
330353	33.5519	32.1984	34.2431	33.3163
330357	34.7492	36.5928	34.1846	35.2059
330359	29.2920	*	*	29.2920
330372	22.5027	28.8482	33.3771	27.5982
330381	29.2438	31.0091	31.8602	30.6612
330385	28.8373	35.6722	33.2246	32.4207
330386	24.6713	17.6383	20.4231	20.5236
330389	32.4234	30.2505	37.3749	32.9392
330390	29.7936	31.1577	30.8744	30.5843
330393	27.9901	26.4958	27.8352	27.4232
330394	18.7724	19.2392	18.9343	18.9816
330395	37.6805	32.8749	32.7494	34.3792
330396	30.7228	34.8648	30.7961	32.1685
330397	31.0043	33.9061	32.6068	32.3768
330398	30.3217	28.7707	29.2872	29.6846
330399	35.5212	32.9100	33.3012	33.9214
330400	*	*	16.2707	16.2707
340001	19.0159	18.1814	19.7093	18.9605
340002	18.7790	20.8858	20.5253	20.0921
340003	21.9674	20.2540	19.5145	20.4958
340004	17.8923	19.0695	20.9863	19.3245
340005	14.0941	15.8205	16.7176	15.5039
340006	17.8145	16.9818	16.5709	17.0955
340007	17.1708	17.2356	18.3399	17.5929
340008	18.3769	21.2889	20.4157	20.0279
340009	20.5011	20.5023	20.9178	20.6132
340010	17.6500	18.3380	19.4302	18.4900
340011	14.9215	13.6554	14.4798	14.3110
340012	16.6574	18.8701	17.5112	17.6905
340013	17.4302	20.1747	19.4613	19.0754
340014	19.9203	20.5748	27.7888	22.1408
340015	19.0056	20.1562	19.4676	19.5517
340016	16.3977	17.5404	18.8958	17.5664
340017	19.2203	19.4192	20.2775	19.6581
340018	15.1579	14.0930	18.1751	15.6569
340019	13.5919	14.8980	15.2887	14.5682
340020	16.7515	18.6334	18.0897	17.8512
340021	19.6658	19.8020	20.5813	20.0277
340022	16.7211	17.8178	18.7714	17.7886
340023	17.2054	18.5414	19.3146	18.3540
340024	16.6389	17.3824	17.9130	17.3104
340025	16.8198	17.2648	18.4628	17.5179
340027	17.2971	18.0816	19.4548	18.2602
340028	17.7196	18.4787	19.9403	18.7490
340030	20.0530	21.1420	22.4709	21.2046
340031	12.3895	14.6951	14.6370	13.8761
340032	20.4735	20.0049	20.7444	20.4083
340035	18.0988	20.2312	18.9930	19.1067
340036	16.9674	18.2190	17.7619	17.6323
340037	15.5347	16.6576	17.5829	16.5842

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
340038	17.0154	17.3762	18.1493	17.5050
340039	20.1470	20.5876	21.3711	20.7125
340040	20.1214	20.4282	20.7237	20.4264
340041	17.7626	15.1419	15.5873	16.0395
340042	16.6300	16.9298	17.0034	16.8680
340044	16.3657	18.8687	18.0863	17.7757
340045	12.4152	13.0538	13.6182	12.9769
340047	19.6050	20.0602	20.0744	19.9132
340049	16.4988	19.2050	19.5127	18.2917
340050	18.5570	20.0090	19.6726	19.4142
340051	18.5953	16.5617	19.3627	18.0980
340052	21.3746	22.8173	23.2134	22.4161
340053	19.4881	20.9495	19.9915	20.1403
340054	14.4722	15.5993	15.5090	15.2167
340055	18.1786	19.6056	19.4035	19.0752
340060	17.9167	18.7137	19.3410	18.6670
340061	20.8474	21.5385	22.1175	21.4855
340063	16.9232	17.0249	16.7377	16.9005
340064	17.2584	20.7125	18.5069	18.8299
340065	18.3212	17.5414	17.3530	17.7394
340067	18.6132	19.3785	19.7187	19.2365
340068	16.7015	16.6305	17.8065	17.0483
340069	19.9948	21.0840	21.6728	20.9166
340070	18.6270	19.7796	20.6829	19.7122
340071	16.3701	17.1424	18.0767	17.2043
340072	15.6014	16.7400	17.7129	16.7307
340073	20.6905	21.9761	23.5832	22.0016
340075	18.2060	18.7090	20.0081	18.9541
340080	16.8453	22.2533	18.2061	19.0642
340084	21.7813	17.1532	19.0103	19.0182
340085	16.2355	17.3462	18.3179	17.3020
340087	16.6987	17.3884	18.2255	17.4652
340088	19.8314	21.0226	22.2322	21.0156
340089	13.8633	13.8535	15.4760	14.4308
340090	17.8457	17.0584	18.5287	17.8139
340091	19.3955	20.5923	20.3861	20.1343
340093	15.1615	16.3276	16.8903	16.0870
340094	15.9568	19.0406	*	17.4328
340096	17.9764	17.8189	19.4696	18.4348
340097	21.3700	18.8412	18.2399	19.4192
340098	20.1671	21.4135	21.9578	21.2065
340099	15.0888	16.8305	15.3752	15.7269
340101	15.3610	13.9994	15.6509	14.9555
340104	15.8729	13.0462	11.5169	13.4465
340105	18.9007	20.2954	*	19.5963
340106	18.0769	17.7220	18.1211	17.9704
340107	16.9503	18.0205	19.3197	18.0904
340109	17.9576	18.7746	19.0532	18.6067
340111	14.9247	16.3344	16.5976	15.9665
340112	14.5966	14.7562	15.5142	14.9625
340113	20.8821	21.2906	21.9883	21.3854
340114	20.8195	21.2166	20.7261	20.9197
340115	18.6700	19.7578	21.7586	20.0594
340116	19.4786	20.4255	20.6800	20.2116
340119	16.8537	18.8507	19.5827	18.4595
340120	14.3822	15.0410	15.8240	15.1047
340121	15.9686	16.3295	17.8771	16.7251
340123	16.2227	16.9114	18.9078	17.3848
340124	14.0462	15.5779	17.4185	15.7171
340125	19.6252	19.7164	20.2748	19.8633
340126	17.7214	18.8100	19.3734	18.6747
340127	17.3849	19.3925	19.3842	18.7105
340129	19.7332	20.4605	20.6521	20.2893

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
340130	19.4430	19.7422	19.8707	19.6940
340131	18.9361	19.7908	21.3849	20.0481
340132	16.9369	17.3448	17.5711	17.3015
340133	14.3501	16.4766	17.2138	16.0568
340137	*	21.0249	31.7702	23.8273
340138	19.2807	20.7618	*	20.0092
340141	22.2234	21.3754	21.4986	21.6898
340142	16.0912	17.1525	18.0766	17.1107
340143	20.9509	21.3604	24.4098	22.2423
340144	19.1919	20.9113	22.9183	20.9333
340145	19.1964	20.1081	19.9233	19.7573
340146	13.0119	15.9203	17.3051	15.3284
340147	19.1087	19.6827	20.5520	19.8121
340148	18.4227	18.5875	18.9912	18.6555
340151	16.5671	16.7275	18.4733	17.2579
340153	20.6588	20.6420	20.7533	20.6847
340155	20.4236	20.5792	23.1021	21.3418
340158	17.2565	18.1439	19.0843	18.2232
340159	16.8048	17.3893	19.0338	17.7595
340160	15.5298	16.1778	16.7170	16.1477
340162	16.6362	14.3472	*	16.3541
340164	19.6820	21.2523	21.5769	20.8240
340166	19.1743	20.0434	20.8270	20.0663
340168	14.7508	15.2919	15.6071	15.2494
340171	20.0495	21.5973	22.4779	21.4041
340173	20.2132	19.3353	21.0898	20.2512
350001	11.7345	14.9080	16.6551	14.4005
350002	17.2834	17.5259	18.3459	17.7122
350003	17.4276	18.2470	19.2840	18.3041
350004	17.9049	20.6518	23.7016	20.6528
350005	16.0259	18.3792	19.9156	18.1833
350006	16.6241	18.4107	19.0343	17.9691
350007	13.2771	13.3292	13.8824	13.4842
350008	21.6983	20.4777	22.3783	21.4889
350009	18.2818	19.1611	18.3688	18.6099
350010	15.2762	16.2808	16.6272	16.0505
350011	18.4931	18.2008	19.1944	18.6474
350012	12.7287	15.7033	18.2524	15.6975
350013	16.6784	16.4579	17.2596	16.7923
350014	15.7906	16.8403	18.0999	16.8354
350015	15.8651	16.3397	17.1071	16.3998
350016	11.6255	11.6524	*	11.6395
350017	17.7835	17.6278	17.5124	17.6446
350018	13.6366	14.4928	16.4939	14.8276
350019	19.4037	19.3063	20.1608	19.6008
350021	12.6885	16.2898	17.7123	15.5294
350023	12.7952	17.9048	17.4983	16.4355
350024	14.3740	14.7529	15.4788	14.8361
350025	16.2400	17.1199	15.0469	16.0889
350027	17.1177	15.0835	15.5178	15.9200
350029	12.7950	13.5219	14.6173	13.6002
350030	17.3497	17.7209	18.1131	17.7195
350033	14.8953	14.9012	16.0870	15.2715
350034	18.3180	18.7245	19.6445	18.8742
350035	10.1561	10.4570	11.7675	10.7676
350038	18.7357	17.6666	19.6854	18.6648
350039	17.3128	17.0361	16.6278	17.0024
350041	14.6772	14.6680	19.1341	15.9095
350042	16.7544	16.7402	19.3309	17.4345
350043	17.1573	16.8876	16.7433	16.9224
350044	10.5296	10.2154	11.0601	10.5801
350047	17.9270	14.4628	18.0094	16.8202
350049	14.5330	14.8019	18.1993	15.6280

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
350050	10.5733	11.4921	12.2183	11.3924
350051	17.5323	17.7279	17.0653	17.4458
350053	13.9379	14.6398	15.9160	14.8075
350055	12.3722	14.5691	15.7916	14.3152
350056	14.7382	14.8293	15.0995	14.8885
350058	14.3484	15.9378	16.7034	15.7009
350060	9.5962	10.3666	10.3076	10.0926
350061	14.5894	15.7269	18.8790	16.4237
360001	17.3933	17.0791	19.6655	18.0423
360002	17.3955	18.0139	18.2613	17.9462
360003	22.0351	22.7471	22.7521	22.5117
360006	22.0906	21.8048	22.4436	22.1137
360007	17.0955	18.0941	14.8213	16.6387
360008	17.8185	18.5439	18.7961	18.3915
360009	17.5328	18.9322	18.9935	18.4667
360010	18.0886	19.2288	19.1852	18.8325
360011	18.9491	19.3835	21.3659	19.9105
360012	19.2221	19.9881	20.0525	19.7649
360013	20.8112	20.6021	21.3690	20.9190
360014	19.8844	20.2390	20.7419	20.2907
360016	18.7709	17.8065	21.2505	19.1632
360017	22.4972	21.7543	22.2740	22.1696
360018	21.3436	23.5219	24.6686	23.0168
360019	20.1726	18.7147	20.6480	19.8139
360020	22.9512	21.7806	22.1751	22.3268
360024	18.5412	19.8508	20.1352	19.5008
360025	19.2918	20.3638	20.2531	19.9763
360026	17.0378	18.2222	17.9523	17.7450
360027	20.3568	21.0406	21.7650	21.0544
360028	17.2681	17.0177	18.7174	17.5937
360029	18.2193	18.7622	19.2928	18.7626
360030	15.3535	17.5748	17.6058	16.8173
360031	19.8987	19.3858	21.0687	20.1028
360032	17.9274	18.6559	19.8020	18.7667
360034	15.5649	14.9534	17.9594	16.1258
360035	20.3358	20.5557	21.0674	20.6574
360036	19.1835	20.2107	20.9916	20.1250
360037	22.5240	23.5094	23.1674	23.0445
360038	19.8921	21.2467	19.9415	20.3576
360039	17.4033	18.7791	19.0013	18.5872
360040	18.1238	18.1618	18.7425	18.3503
360041	18.4244	19.5744	19.7968	19.2697
360042	16.1187	17.4306	17.1952	16.9328
360044	16.7925	17.0612	17.6882	17.1993
360045	21.1814	22.1471	22.4018	21.8209
360046	19.3198	20.4755	20.4607	20.0909
360047	15.3399	17.1871	15.2922	15.8884
360048	21.1719	22.5857	22.4890	22.0646
360049	18.8084	20.4564	20.8393	20.0008
360050	12.8888	12.9873	15.0568	13.6080
360051	20.9461	20.8338	20.8757	20.8844
360052	20.0182	19.6233	18.7931	19.5088
360054	16.1875	17.2574	17.4911	16.9860
360055	23.2671	21.5585	21.4112	22.0925
360056	18.7606	19.0474	20.6968	19.5385
360057	13.8094	15.0146	15.8569	14.8518
360058	17.9178	18.6992	19.3306	18.6392
360059	21.9689	20.5618	19.9304	20.8679
360062	20.3111	20.7588	21.9195	20.9548
360063	22.7866	18.4512	17.5108	19.4998
360064	20.6416	20.4846	20.0615	20.4087
360065	19.4531	20.0532	19.6199	19.7128
360066	20.0285	21.6015	22.8175	21.4937

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
360067	14.5687	15.3157	14.2745	14.7189
360068	21.2199	21.2789	22.6227	21.7164
360069	17.8329	16.6982	14.6597	16.2292
360070	17.5300	17.3758	18.8406	17.9171
360071	23.8013	17.9756	19.0302	20.2494
360072	17.9697	18.1467	19.0166	18.3995
360074	18.2614	20.8275	18.5889	19.1849
360075	18.4733	22.4523	26.0663	21.4074
360076	19.5864	20.0700	20.3317	20.0010
360077	20.8202	21.1053	21.5517	21.1550
360078	20.7940	21.4392	22.6490	21.6280
360079	22.0033	22.1096	21.6644	21.9274
360080	16.6414	17.3892	17.6369	17.2080
360081	19.6354	21.7342	20.4614	20.6451
360082	22.8585	22.9460	20.7610	22.1460
360083	18.4635	*	*	18.4635
360084	20.0914	20.4894	22.0492	20.8664
360085	21.6670	21.9051	21.5151	21.7121
360086	17.0389	19.5378	19.3701	18.5836
360087	20.0395	20.1684	20.7969	20.3249
360088	22.3121	24.0097	24.0822	23.4637
360089	20.5610	18.3881	18.1941	19.0415
360090	20.3955	21.0376	20.8971	20.7887
360091	21.0335	21.3126	21.8447	21.4132
360092	15.9095	20.4534	21.5073	18.9727
360093	18.5744	19.3292	19.0261	18.9905
360094	18.3105	18.8780	20.1227	19.0848
360095	18.7079	20.4149	19.8521	19.6643
360096	17.1617	18.2215	19.6726	18.3160
360098	18.3361	19.5314	19.8178	19.2371
360099	18.5523	18.5855	19.6241	18.9389
360100	17.6554	17.8989	18.0442	17.8625
360101	22.3121	21.3914	20.2635	21.3487
360102	19.7700	19.4345	18.5367	19.2837
360103	22.6228	*	*	22.6228
360106	16.1843	18.9752	19.1778	18.1964
360107	18.6195	19.7599	22.1359	20.1794
360108	16.5076	17.5832	20.0681	18.0497
360109	19.5162	20.1032	19.9237	19.8530
360112	22.5676	22.5589	24.6335	23.2167
360113	22.4584	24.2654	20.8154	22.4061
360114	16.3288	17.8761	18.7509	17.6758
360115	18.1859	18.8059	20.7652	19.2888
360116	18.0835	18.8882	18.8319	18.6000
360118	18.6098	19.3732	19.9141	19.3196
360121	21.0979	22.1093	22.2175	21.8088
360123	19.1313	20.3236	20.9792	20.1480
360125	18.1756	19.0774	20.5508	19.2432
360126	20.4558	19.0036	24.5387	21.1181
360127	16.9228	17.5882	16.5559	16.9955
360128	15.5823	16.1243	17.0515	16.2361
360129	15.5241	15.5002	16.6114	15.8783
360130	15.3356	17.2009	18.4539	16.9275
360131	18.2897	19.2241	18.4688	18.6543
360132	18.2733	19.9171	21.3493	19.8413
360133	19.0349	19.4316	20.2857	19.5509
360134	20.2383	20.6876	20.9564	20.6143
360136	17.8473	17.7827	18.2194	17.9464
360137	20.2581	20.1756	22.3648	20.9095
360140	19.1263	20.2791	21.2881	20.2299
360141	22.8496	23.0016	23.5343	23.1176
360142	17.3154	17.0059	18.3188	17.5468
360143	20.4378	20.1989	21.0336	20.5552

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
360144	21.9159	23.2191	20.9033	21.9858
360145	19.3907	19.6413	20.0513	19.6956
360147	16.5898	16.6616	17.6779	16.9779
360148	18.8914	19.2816	19.1393	19.1100
360149	18.7891	19.9808	*	19.3785
360150	20.6253	21.1327	22.3620	21.3641
360151	17.4863	16.6019	19.2788	17.7101
360152	21.9978	20.8328	21.6005	21.4611
360153	14.8948	15.4132	16.7399	15.6460
360154	13.7761	14.3270	14.3593	14.1608
360155	20.8977	22.5347	22.2112	21.8776
360156	17.9155	17.8787	18.9095	18.2225
360159	20.7119	20.2841	21.5695	20.8609
360161	19.4122	19.1983	20.6160	19.7228
360162	18.6084	*	*	18.6084
360163	20.3821	20.7275	21.2689	20.8164
360164	16.1643	*	*	16.1643
360165	19.4831	18.2571	18.2417	18.6524
360166	16.9778	18.7321	*	17.8568
360170	17.1779	16.4653	20.4407	17.9153
360172	18.4690	18.6720	19.8909	19.1486
360174	19.0887	19.9725	20.5399	20.0142
360175	20.4133	21.1685	21.5450	21.0739
360176	15.4730	15.9430	16.6228	16.0305
360177	19.4122	18.7898	18.9576	19.0368
360178	17.3985	18.8704	16.7962	17.7254
360179	19.1417	21.1309	20.7069	20.2966
360180	22.0949	21.3826	21.0146	21.4888
360184	19.3502	19.1224	*	19.2391
360185	18.6697	18.7291	19.4858	18.9599
360186	20.8579	18.3246	20.7572	19.9570
360187	18.0209	18.5109	19.6535	18.7427
360188	17.5327	17.1044	18.3057	17.6838
360189	17.3713	17.8981	18.5940	17.9373
360192	20.9980	21.6365	22.7846	21.8042
360193	17.6874	*	*	17.6874
360194	17.6890	17.1884	17.6140	17.4968
360195	19.0173	19.9302	20.5828	19.8368
360197	19.4250	20.0603	20.5062	19.9981
360200	17.7583	16.2306	17.9623	17.3129
360203	15.6212	16.3181	15.9609	15.9716
360204	19.3543	22.2494	*	20.5754
360210	20.2809	20.9955	21.8629	21.0428
360211	19.5762	19.9895	20.6081	20.0860
360212	20.2288	21.1123	20.6987	20.6781
360213	18.3253	19.4765	19.0584	18.9547
360218	18.4140	18.9469	18.8204	18.7231
360230	21.4385	21.9763	20.8042	21.3850
360231	13.5586	12.9588	14.4168	13.6102
360234	22.4324	23.2588	20.6131	22.0967
360236	19.4881	17.8426	21.4628	19.5088
360239	19.8584	20.1854	19.2375	19.7767
360241	22.0795	23.5318	25.3741	23.5406
360243	13.5835	14.8694	*	14.2018
360244	10.5518	*	*	10.5518
360245	15.0579	16.4622	15.9782	15.8310
360247	18.1116	16.3092	17.0776	17.0967
360248	21.6499	*	*	21.6499
360249	*	*	25.4331	25.4331
370001	21.2714	22.5214	24.1929	22.6419
370002	14.0847	14.7315	15.4333	14.7194
370004	16.7671	19.3236	18.5233	18.1546
370005	17.3817	15.1654	15.3881	15.9167

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
370006	12.9493	16.6484	16.4995	15.3118
370007	17.1535	15.2905	15.8312	16.0498
370008	17.3048	16.6566	17.5553	17.1688
370011	14.6397	14.9701	15.6178	15.0345
370012	10.8003	11.7265	12.4942	11.6228
370013	18.0385	19.3398	18.9584	18.7911
370014	19.6543	20.6512	20.2858	20.2276
370015	17.8247	17.0319	20.8765	18.5256
370016	16.6401	19.1191	19.1613	18.3470
370017	12.9837	12.6400	13.6531	13.1239
370018	14.2438	18.5107	17.7054	16.6955
370019	16.8801	14.2277	14.6216	15.1546
370020	13.4787	14.3798	15.1035	14.3356
370021	11.2639	12.0474	12.9030	12.0738
370022	17.9015	17.2344	17.3724	17.4872
370023	16.8215	17.7630	17.5148	17.3665
370025	16.3970	17.4988	18.4815	17.4661
370026	16.8991	18.3371	18.0412	17.7563
370028	19.7118	18.4445	21.1292	19.7322
370029	13.8930	16.4924	18.2580	16.0663
370030	15.4736	16.3269	16.5803	16.1058
370032	16.6432	18.2821	18.1538	17.7030
370033	12.3910	13.5216	11.3210	12.4595
370034	14.5101	15.6386	15.6288	15.2811
370035	18.9629	25.5764	*	21.9610
370036	11.4593	12.4026	12.4070	12.0833
370037	17.7491	16.7012	18.9556	17.7764
370038	12.8135	13.3084	13.0210	13.0660
370039	16.2661	15.5206	19.4498	17.0406
370040	14.2582	14.4672	15.5109	14.7638
370041	17.4123	16.7356	16.2316	16.8488
370042	14.6146	14.9175	15.2764	14.9764
370043	16.0764	15.9534	17.0892	16.3549
370045	12.4352	10.1994	11.3560	11.2236
370046	18.1499	18.8334	*	18.4831
370047	15.6716	16.7554	17.8769	16.7444
370048	17.4356	18.2150	15.6803	17.1206
370049	19.8397	20.7176	19.4868	19.9892
370051	12.1816	11.6736	12.5171	12.1083
370054	16.5598	16.9049	18.0787	17.1343
370056	18.8774	18.4558	18.1432	18.4804
370057	14.6564	16.7261	15.1228	15.5054
370059	16.4578	18.1386	18.3314	17.6259
370060	15.1169	16.5403	19.3051	16.8157
370063	17.0645	14.4132	16.7342	16.0603
370064	8.7499	10.9676	11.9954	10.6741
370065	16.5638	16.6898	18.1349	17.1281
370071	14.9472	16.1439	16.4567	15.8354
370072	14.6497	14.4742	13.6519	14.2760
370076	12.8568	13.5694	14.3555	13.5818
370077	17.6236	*	*	17.6236
370078	17.2370	18.4086	19.2412	18.2505
370079	13.5976	16.6861	16.9201	15.7005
370080	14.3445	13.9239	14.7323	14.3058
370082	13.5434	13.9634	15.0669	14.1855
370083	11.4905	13.1519	13.1810	12.6268
370084	21.7484	22.0545	13.1197	17.8063
370085	11.8844	11.2842	48.1271	14.9179
370086	13.5646	15.4404	11.1900	13.1933
370089	14.4968	16.0966	17.2638	15.9758
370091	17.5839	19.1698	20.1822	18.9743
370092	14.6757	14.9802	15.7678	15.1529
370093	18.5747	18.4600	19.7008	19.0469

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
370094	18.3796	18.0002	19.5462	18.6588
370095	14.1319	12.6383	13.4202	13.3755
370097	23.3116	22.9714	23.2056	23.1716
370099	16.2649	15.4549	19.4646	16.8783
370100	17.1036	14.0168	18.8274	16.6764
370103	15.8967	19.2353	18.2685	17.7516
370105	17.6811	21.3352	20.7890	19.9853
370106	18.6238	18.5485	20.3651	19.1398
370108	12.2379	12.3279	12.7470	12.4421
370112	15.2488	14.8539	15.3039	15.1287
370113	16.2043	16.1046	17.6107	16.6143
370114	15.9801	16.5268	17.8941	16.8136
370121	19.5506	22.5611	21.3099	21.1472
370122	12.1514	15.0645	15.4375	13.9736
370123	16.3609	18.9159	19.0313	18.0343
370125	13.5453	15.6284	13.9436	14.3107
370126	18.2447	23.9654	15.8020	19.1824
370131	16.2403	17.5689	15.7261	16.4650
370133	10.0169	10.9575	12.9545	11.1921
370138	15.9372	16.4005	17.5551	16.6500
370139	13.3023	14.8612	14.9964	14.3624
370140	15.2265	16.0721	17.1393	16.1657
370141	12.1420	18.4101	20.7798	16.3574
370146	12.5581	12.6402	13.0399	12.7467
370148	16.4147	20.6458	20.6612	19.2220
370149	16.7218	16.1850	17.0929	16.6647
370153	15.3218	17.8352	16.4669	16.5507
370154	15.9128	15.5127	15.6093	15.6789
370156	13.6363	13.9255	14.5696	14.0273
370158	15.0865	15.6917	15.6994	15.4906
370159	17.8319	28.0536	21.1267	21.7006
370163	14.5609	17.6361	20.4217	17.2893
370165	13.2174	13.0910	13.0375	13.1156
370166	17.8154	17.2849	21.0797	18.6456
370169	9.4807	12.5243	12.7138	11.5273
370176	16.0355	15.9476	18.9951	16.9629
370177	11.8757	11.2536	14.6481	12.5743
370178	11.6384	10.5726	11.6200	11.2422
370179	19.2677	17.2829	21.3002	18.9651
370183	7.6164	10.2945	16.9318	11.0088
370186	13.3454	13.6192	15.4533	14.1321
370190	13.7032	14.1397	19.3570	15.3737
370192	16.7402	18.4614	19.6967	18.2866
370197	21.5718	*	*	21.5718
370198	*	21.3136	*	21.3136
370200	*	*	22.5299	22.5299
380001	22.0255	20.3127	26.4822	22.5494
380002	19.4764	24.0241	21.9185	21.9840
380003	24.7434	21.7826	20.9007	22.2865
380004	23.1432	23.1451	23.3609	23.2208
380005	23.2415	24.0838	25.0750	24.1485
380006	20.5375	21.2731	21.3520	21.0653
380007	24.2933	25.2995	32.2678	27.0282
380008	21.1888	20.7063	22.3004	21.4082
380009	25.1702	23.8104	24.3851	24.4234
380010	19.7477	23.7488	22.7276	21.8451
380011	21.1353	21.1151	20.3357	20.8683
380013	20.1038	18.6818	19.8180	19.5721
380014	23.4819	24.6574	25.9828	24.7413
380017	23.8231	26.0578	25.3954	25.0552
380018	22.0776	22.3525	22.9822	22.4971
380019	20.7700	22.1215	20.8176	21.2209
380020	21.3556	20.1464	22.9568	21.5448

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
380021	20.6358	21.1590	23.8499	21.8371
380022	21.6110	22.6408	24.5974	22.8841
380023	19.2357	20.5462	21.3831	20.3976
380025	24.6738	26.3652	26.9346	25.9824
380026	19.2663	20.4706	20.6972	20.1525
380027	20.1576	20.8647	21.5490	20.8958
380029	18.5699	19.4246	20.1471	19.4015
380031	22.8346	23.3181	20.3396	22.1492
380033	23.2881	25.2454	27.1343	25.1500
380035	21.6533	22.4099	23.9719	22.6232
380036	19.3269	27.1587	27.2157	23.8613
380037	21.2347	21.9158	22.1774	21.7911
380038	25.5750	26.0869	26.7759	26.1419
380039	22.1235	23.1746	22.8048	22.6937
380040	21.6378	26.2717	22.5477	23.4095
380042	19.8096	21.1176	24.4172	21.7244
380047	21.9511	23.0718	24.2524	23.1258
380048	18.3847	17.5885	18.3005	18.0671
380050	18.2486	20.3934	20.3205	19.6254
380051	21.2358	22.3568	22.3207	21.9927
380052	17.8741	19.4570	18.6299	18.6300
380055	21.2459	*	*	21.2459
380056	17.1600	19.5185	18.4961	18.3892
380060	23.2923	24.2670	24.2059	23.9182
380061	22.5983	22.3736	22.8781	22.6217
380062	18.5229	20.7716	18.2148	19.1910
380063	19.3566	20.4077	*	19.9113
380064	19.8719	19.9826	22.9160	20.8404
380065	22.1706	26.1404	22.9608	23.6770
380066	20.4189	22.0349	23.2794	21.9793
380068	22.7573	22.3178	*	22.5559
380069	19.5793	19.8300	20.4882	19.9809
380070	24.7116	27.2541	27.7790	26.6130
380071	20.4707	22.6386	25.1808	22.8743
380072	16.3169	19.1553	19.4346	18.3236
380075	22.1703	22.3625	22.4139	22.3203
380078	19.1035	20.2507	21.0903	20.1439
380081	20.5902	20.9882	20.4082	20.6790
380082	22.5856	22.2275	22.9606	22.5990
380083	21.8096	21.3859	21.7431	21.6440
380084	23.6412	24.2844	27.1689	24.9815
380087	14.0976	16.5309	17.0380	15.8783
380088	19.5204	21.5225	19.5346	20.1728
380089	23.7413	19.5255	25.2908	23.0572
380090	27.0867	29.2702	24.9351	26.9453
380091	22.8333	27.5560	25.3062	25.1774
390001	18.6384	19.2989	19.6732	19.2277
390002	18.0787	21.8353	19.7833	19.8184
390003	17.2435	17.1371	18.1025	17.4798
390004	18.8899	19.2277	20.3204	19.4755
390005	16.4459	17.3506	16.9472	16.9256
390006	19.6012	20.2959	21.1786	20.3254
390007	21.4093	21.7506	21.3839	21.5152
390008	16.7440	17.8297	18.2743	17.6097
390009	20.1181	20.6507	20.6241	20.4567
390010	17.2315	17.5127	17.3335	17.3583
390011	18.0683	18.1717	18.3257	18.1941
390012	20.0227	20.6523	21.0610	20.5672
390013	19.3300	19.2698	19.6562	19.4200
390015	12.9372	13.1337	13.7352	13.2647
390016	17.0679	16.9892	17.1133	17.0565
390017	16.2170	16.7493	18.6113	17.1752
390018	19.1241	21.3626	19.0279	19.8558

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
390019	16.3965	16.7848	17.7258	16.9784
390022	22.8967	21.5064	24.8468	23.0587
390023	19.5639	21.8270	22.1044	21.4167
390024	25.0359	24.9437	25.4606	25.1433
390025	15.7111	15.6155	15.5523	15.6287
390026	22.7645	22.3902	22.9718	22.7143
390027	27.6893	26.8878	29.5940	28.0411
390028	20.1087	22.7700	23.6571	22.0510
390029	19.6883	21.5729	21.2661	20.8012
390030	18.3978	17.9580	18.6887	18.3432
390031	19.5175	19.2755	18.8162	19.2068
390032	18.1492	17.8041	21.5105	19.0439
390035	18.5146	20.2029	22.3591	20.2740
390036	18.8657	19.9880	19.7671	19.5278
390037	22.2359	21.0616	20.4263	21.2243
390039	16.5438	17.1046	17.5300	17.0475
390040	15.1211	15.9612	16.6876	15.9078
390041	19.5760	19.8080	20.4397	19.9243
390042	21.1276	22.7693	22.5775	22.1662
390043	16.3561	17.2607	17.4764	17.0230
390044	19.5419	20.2813	20.9831	20.2788
390045	18.4591	18.5574	19.4677	18.8305
390046	20.4608	20.7303	21.7445	20.9727
390047	24.5824	27.6661	26.9709	26.2900
390048	18.3801	19.0920	19.7992	19.0527
390049	21.1318	21.1217	22.1586	21.4802
390050	20.9240	22.8808	22.2639	22.0253
390051	26.0485	25.7910	28.1385	26.5675
390052	17.0988	20.9306	20.1195	19.3733
390054	17.4382	17.8852	18.4975	17.9431
390055	25.8961	24.2211	23.4017	24.4911
390056	17.1692	17.7858	19.3901	18.0977
390057	19.7459	20.2059	20.2395	20.0600
390058	19.2543	19.7379	20.3520	19.7916
390060	13.6276	*	*	13.6276
390061	20.4819	21.2392	23.8722	21.8310
390062	16.4505	16.6721	17.3750	16.8291
390063	19.6373	20.0125	19.4965	19.7211
390065	20.0001	19.9361	20.0473	19.9948
390066	18.7064	19.8539	18.9296	19.1567
390067	20.6515	20.9688	20.8162	20.8116
390068	17.5524	18.3158	19.1109	18.3267
390069	19.2858	19.6466	*	19.4555
390070	20.1862	16.1988	21.8549	19.3957
390071	16.2298	15.7165	16.0100	15.9856
390072	15.5565	16.3133	16.9232	16.2264
390073	20.6859	20.5581	21.2623	20.8422
390074	16.5971	18.4806	18.3093	17.7465
390075	17.2676	17.9840	18.7695	17.9105
390076	21.4307	20.2475	21.3290	20.9889
390078	18.2328	19.2089	19.0156	18.8052
390079	18.1969	18.3312	18.9269	18.4731
390080	19.5180	18.8028	21.4707	19.8661
390081	23.9922	24.8351	24.7461	24.5194
390083	20.5919	*	*	20.5919
390084	16.3463	16.4026	20.2529	17.4556
390086	17.2481	18.5265	18.3563	18.0522
390088	23.4941	23.6173	23.9506	23.6668
390090	20.6463	21.6437	21.3759	21.2068
390091	18.3746	18.1569	18.3770	18.3019
390093	16.6336	17.7171	18.4442	17.6019
390095	13.0459	16.3357	16.6930	15.2335
390096	19.3118	19.1171	22.4382	20.4516

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
390097	21.4115	23.5963	25.2845	23.2449
390100	20.3014	20.7859	20.9263	20.6729
390101	17.0534	17.9499	18.5039	17.8169
390102	19.4924	19.0461	21.5496	20.0293
390103	17.7054	18.4312	18.8667	18.3176
390104	15.9605	15.9008	16.3255	16.0548
390106	16.2783	16.6666	16.8439	16.6044
390107	19.1793	19.5178	20.9841	19.9123
390108	21.2872	21.0899	21.3142	21.2288
390109	14.6645	16.4597	16.5299	15.8639
390110	21.3191	21.5282	21.6464	21.5043
390111	28.7875	27.5193	33.3971	29.8383
390112	14.0439	14.9427	15.0065	14.6808
390113	17.9377	19.1945	19.3634	18.8262
390114	22.9698	19.6295	20.9533	21.1250
390115	24.7244	23.3461	21.4287	23.0792
390116	20.6016	21.4877	21.3671	21.1457
390117	16.9036	17.9393	18.0769	17.6425
390118	16.8962	18.3440	18.9507	18.0638
390119	18.5935	18.2951	18.8815	18.5863
390121	18.6422	20.8780	19.1315	19.5644
390122	17.4645	17.1902	17.7734	17.4764
390123	20.8412	20.8344	21.3974	21.0254
390125	15.9356	16.7983	17.5446	16.7393
390126	20.9383	20.6498	*	20.8020
390127	21.8849	21.7724	22.4555	22.0398
390128	19.4132	19.6792	19.3165	19.4699
390130	17.3253	17.7049	18.3695	17.7936
390131	16.8349	16.0986	19.2096	17.3202
390132	20.5528	21.1931	22.8414	21.4849
390133	24.6131	23.3489	24.7561	24.1960
390135	21.2497	21.5782	22.1905	21.6491
390136	17.6128	16.9737	20.6286	18.3801
390137	16.5598	17.5687	18.5397	17.5480
390138	18.8601	19.6212	20.6936	19.7394
390139	22.9351	24.4515	23.9757	23.7712
390142	26.7954	26.8086	28.8877	27.5656
390145	20.3393	20.3731	20.4228	20.3787
390146	17.7020	18.7922	18.6505	18.3503
390147	21.1085	20.9651	21.2492	21.1067
390150	19.6575	20.7294	20.3155	20.2474
390151	20.5084	21.6000	22.5206	21.5535
390152	19.1525	20.3353	19.4017	19.6203
390153	23.1183	23.7013	22.9707	23.2621
390154	15.8478	17.4036	16.7052	16.6538
390156	21.1629	21.8498	22.6398	21.8660
390157	19.8268	19.6578	19.1783	19.5633
390158	21.6045	*	*	21.6045
390160	20.7676	21.4810	19.4463	20.4967
390161	12.3743	16.4799	*	14.3389
390162	21.0228	21.4095	21.9188	21.4386
390163	15.6227	16.8013	17.7564	16.7297
390164	21.5890	24.6765	24.9750	23.5327
390166	19.9612	19.0405	19.7978	19.5957
390167	22.9136	19.8973	*	21.3982
390168	18.9936	18.7400	18.8863	18.8736
390169	18.9878	20.2382	22.0547	20.4487
390170	22.9877	26.5891	24.7973	24.6450
390173	17.8568	18.5370	18.6613	18.3502
390174	25.2407	25.4189	25.3307	25.3310
390176	17.3577	17.8740	20.8368	18.6587
390178	17.7036	16.6993	17.0534	17.1490
390179	21.4093	21.6901	21.8593	21.6579

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
390180	25.1191	25.7074	26.5541	25.8271
390181	17.0860	19.4654	19.3832	18.6237
390183	19.0834	17.8306	17.9848	18.2942
390184	20.7489	20.8060	20.9349	20.8256
390185	17.6516	18.8798	20.3877	18.9752
390189	18.6668	20.0889	20.3338	19.6907
390191	16.1993	16.3240	17.2270	16.5760
390192	16.3696	17.4537	17.6597	17.1476
390193	16.4663	16.7874	18.1209	17.0634
390194	20.1547	20.7953	21.2689	20.7092
390195	23.6920	24.6855	24.1793	24.1876
390197	18.9857	19.2690	20.7998	19.6927
390198	15.4508	15.9721	15.8833	15.7671
390199	16.6644	17.0515	17.3865	17.0306
390200	13.5898	15.1399	15.4012	14.7971
390201	20.5011	20.6296	20.3533	20.4916
390203	21.1895	20.9432	21.4989	21.2088
390204	20.8483	20.1779	22.9616	21.3067
390206	18.5746	18.4027	*	18.4910
390209	16.9558	17.4792	18.7059	17.7155
390211	17.9132	17.8638	18.4213	18.0846
390213	17.4453	18.8555	19.1553	18.5312
390215	21.4291	20.7084	21.2032	21.1048
390217	19.2926	19.1406	19.9837	19.4647
390219	21.6295	18.8292	19.6226	19.9600
390220	18.5178	18.7178	17.7916	18.3301
390222	20.9080	21.5739	22.1548	21.5483
390223	22.6498	23.6482	22.1775	22.7892
390224	15.9058	15.3015	13.7518	14.9518
390225	18.1752	18.6125	18.7290	18.5053
390226	23.1638	21.8268	21.8481	22.2835
390228	19.8129	19.4083	19.8180	19.6802
390231	24.4852	22.7544	19.4798	21.9903
390233	18.7707	19.4887	20.2309	19.5042
390235	24.6044	25.0857	21.4200	24.0078
390236	17.0339	16.2397	17.8735	17.0494
390237	21.7479	19.5230	22.3011	21.1430
390238	*	17.8211	17.1055	17.4821
390242	18.0943	*	*	18.0943
390244	14.4133	15.4611	15.6402	15.1810
390245	20.1544	26.0194	24.5076	23.4886
390246	17.9214	18.9733	25.0556	20.2904
390247	20.6671	20.9526	21.2151	20.8919
390249	10.7336	12.7920	13.1657	12.2298
390256	23.7828	20.9469	22.2773	22.2601
390258	21.3629	21.9207	22.6852	21.9998
390260	21.1917	21.9509	21.5982	21.5728
390262	18.6684	18.2379	*	18.4504
390263	20.0939	20.6855	20.3796	20.3890
390265	19.5089	20.3580	20.4950	20.1207
390266	16.2372	17.1666	17.1966	16.8552
390267	20.5125	21.2974	19.2665	20.4773
390268	21.0161	21.3486	22.0909	21.4791
390270	17.8280	19.0925	19.2074	18.7055
390277	27.0983	*	*	27.0983
390278	19.2019	18.2865	17.7176	18.4620
390279	13.6992	14.3241	14.8655	14.2998
390283	*	*	22.5490	22.5490
390284	*	*	34.3904	34.3904
400001	9.8615	9.9463	10.5757	10.1359
400002	9.3063	10.1417	13.0494	10.8249
400003	9.9865	10.8821	12.4078	11.0633
400004	8.4811	8.9864	8.5648	8.6695

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
400005	7.8494	9.5632	7.7432	8.3858
400006	10.5281	10.3444	10.1048	10.3288
400007	7.8637	6.4490	8.0174	7.3754
400009	8.3727	8.4207	8.8650	8.5497
400010	11.6642	10.6518	10.8011	10.9779
400011	5.6825	7.4979	8.5426	7.2512
400012	7.8134	8.2412	8.4728	8.1883
400013	8.2066	8.4579	9.2624	8.6839
400014	9.5354	9.5235	9.4798	9.5126
400015	10.3326	10.9505	14.4076	11.3577
400016	12.0743	13.2756	13.3922	12.9125
400017	8.5675	8.6421	9.2577	8.8024
400018	9.4534	10.4557	10.6208	10.1978
400019	10.1512	10.4332	10.8940	10.5307
400021	9.9121	10.6988	12.1434	10.9538
400022	11.1204	11.5861	12.2199	11.6336
400024	7.5594	7.8984	9.2409	8.1615
400026	7.1236	5.6454	5.8335	6.1312
400027	8.4862	9.5899	*	9.0120
400028	8.3991	8.8597	9.1794	8.7817
400031	9.7826	8.2660	*	8.9857
400032	9.7291	10.5498	10.0448	10.1074
400044	11.7484	11.9704	11.9486	11.8844
400048	8.9224	9.1701	15.1405	10.3604
400061	12.2770	12.4493	13.0988	12.5813
400079	7.0830	*	9.7203	8.1082
400087	10.3972	9.5097	9.8534	9.8687
400094	7.8208	8.9116	7.9187	8.1829
400098	7.2098	9.3308	9.7791	8.8630
400102	7.7288	9.8536	9.9903	9.1668
400103	10.7316	11.2069	11.5359	11.1167
400104	9.9416	11.0672	10.7292	10.5214
400105	10.1726	9.3049	9.0556	9.5335
400106	8.5143	9.3123	9.2187	9.0108
400109	10.1786	10.9826	11.8760	11.0486
400110	10.5250	10.3326	10.5277	10.4760
400111	9.5600	9.5583	10.9665	10.1021
400112	12.8478	10.1755	10.8694	11.2941
400113	9.4835	9.2238	8.3168	9.0068
400114	6.4076	9.0496	7.0510	7.4630
400115	9.1311	9.8244	8.5487	9.1780
400117	10.0381	10.2295	10.8756	10.3823
400118	8.6964	9.4398	11.4051	9.9004
400120	9.7425	9.5274	10.6584	9.9956
400121	7.1061	7.8052	9.8322	8.2686
400122	8.4806	8.1911	7.6413	8.0571
400123	9.0217	7.8099	10.2367	9.0130
400124	11.4839	12.0999	12.2452	11.9729
400125	*	*	10.2056	10.2056
410001	22.5322	23.2808	23.1738	23.0006
410004	22.3212	22.4801	21.0638	22.0103
410005	21.2407	23.1444	22.7170	22.3365
410006	21.9798	23.3968	23.8700	23.0621
410007	20.9489	22.1452	23.1325	22.1106
410008	22.6133	23.0662	24.9726	23.5244
410009	24.0769	24.4899	24.3895	24.3200
410010	27.1426	26.9813	28.4589	27.5328
410011	24.3676	25.2926	26.1183	25.2512
410012	21.3337	24.5811	24.1695	23.4018
410013	25.0050	24.5122	24.8800	24.7951
420002	20.2049	19.4845	20.7804	20.1513
420004	19.4079	19.7968	20.9588	20.0732
420005	15.9906	17.3510	17.9694	17.1171

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
420006	18.2374	18.3439	19.1760	18.5687
420007	17.5783	18.2096	18.6456	18.1319
420009	17.2515	18.5456	19.9586	18.6114
420010	17.9141	17.1184	18.0252	17.6914
420011	14.9944	16.5664	18.0970	16.4913
420014	16.7219	16.6065	18.0519	17.0894
420015	17.1802	18.8411	20.1164	18.5841
420016	18.1451	15.6241	15.5485	16.2939
420018	19.7285	19.7367	21.8775	20.3791
420019	15.5521	16.9990	17.1726	16.5419
420020	17.9011	20.9449	20.3193	19.6942
420023	20.9663	19.4855	20.4053	20.2598
420026	21.8968	20.3476	21.8749	21.3678
420027	18.0774	18.8457	19.2594	18.7307
420029	18.3557	*	*	18.3557
420030	17.8215	19.1453	20.6448	19.3038
420031	13.0718	14.1855	8.2516	11.1227
420033	21.0863	21.7279	23.1303	21.9705
420036	19.7421	17.6136	21.3222	19.4565
420037	21.9603	21.7908	22.7099	22.1669
420038	16.1498	17.6726	18.6568	17.4393
420039	16.9646	15.8385	18.3017	17.0260
420042	14.6567	*	*	14.6567
420043	18.3607	19.4521	19.7570	19.1785
420048	18.0286	18.4367	18.8070	18.4223
420049	19.2340	17.5854	19.4049	18.7208
420051	18.2518	19.5001	19.1555	18.9941
420053	16.5452	16.9599	18.1657	17.1887
420054	16.5474	18.2702	20.2574	18.3229
420055	16.1823	19.2048	16.8717	17.3777
420056	15.5966	14.8695	15.1835	15.1636
420057	14.5006	15.9849	20.5266	17.2252
420059	19.1303	15.8160	17.1483	17.3325
420061	16.1310	16.5555	17.3543	16.6881
420062	18.9513	17.8205	21.7469	19.4924
420064	15.4531	16.7227	16.0794	16.0985
420065	19.0645	19.6902	19.9435	19.5673
420066	15.5001	15.1804	18.0042	16.2261
420067	18.3106	18.8610	19.7824	19.0239
420068	17.2144	18.5030	18.5481	18.0958
420069	16.3189	17.0788	18.1298	17.2134
420070	17.4486	18.0057	17.3876	17.6174
420071	18.2878	19.4482	20.3902	19.3836
420072	12.6013	13.8550	15.0158	13.8117
420073	19.2011	19.1604	19.9986	19.4566
420074	13.8038	16.9292	18.0967	16.2019
420075	16.2946	14.2931	12.8158	14.3372
420078	20.6818	20.7317	21.9082	21.1259
420079	18.7710	20.8639	21.0874	20.2636
420080	24.8321	22.3443	21.9968	22.9897
420081	20.4211	*	*	20.4211
420082	18.8848	20.4653	21.7210	20.3535
420083	23.3425	20.1472	22.6376	21.9902
420085	18.5502	19.9603	21.6791	20.1188
420086	19.3054	25.7179	20.2878	21.4636
420087	18.4016	19.1403	19.8388	19.1412
420088	17.9063	17.1938	19.9919	18.3046
420089	21.6608	20.2537	20.5360	20.7623
420091	18.5723	18.8687	20.3092	19.2195
420093	16.7734	17.4689	18.3902	17.5654
420094	32.6768	*	*	32.6768
430004	17.8435	18.5438	19.6344	18.6310
430005	15.8449	16.3059	16.4560	16.2068

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
430007	14.0586	14.1078	14.6331	14.2620
430008	16.7640	17.6640	18.1323	17.5240
430010	16.1093	17.1766	19.8191	17.5891
430011	16.4234	16.9848	17.4750	16.9703
430012	17.7809	17.2775	17.6997	17.5855
430013	17.2424	18.1338	18.4817	17.9391
430014	18.4417	16.8925	20.2387	18.3922
430015	16.4123	18.0019	18.2875	17.5236
430016	18.9715	19.4759	20.8850	19.7559
430018	14.9100	14.8854	16.2244	15.3323
430022	12.9532	13.4905	14.5118	13.6222
430023	11.6383	12.2331	16.2164	13.2302
430024	13.9942	15.4709	16.1801	15.3449
430026	10.8532	*	*	10.8532
430027	18.6367	19.1461	20.2591	19.2968
430028	16.7185	18.2312	17.1577	17.3522
430029	15.1010	16.6500	17.6986	16.5066
430031	12.4631	13.1258	12.4660	12.6792
430033	14.6423	15.3003	17.3652	15.6688
430034	12.8513	15.4064	14.2491	14.1740
430036	13.7807	13.6967	15.6258	14.3461
430037	15.9545	16.5368	18.1293	16.8632
430038	11.9419	13.7167	18.4078	14.2118
430040	13.3722	13.6745	14.4509	13.8057
430041	12.6235	13.1936	14.8816	13.4964
430043	13.4288	13.6908	14.9949	14.0204
430044	16.4488	18.4970	21.0823	18.5195
430047	15.6227	17.4956	17.9823	16.9377
430048	17.2589	18.3524	18.7602	18.0996
430049	14.4354	15.5381	15.2237	15.0640
430051	17.2139	17.0574	18.8070	17.6987
430054	13.5011	14.7251	14.8003	14.3524
430056	11.4117	11.7627	10.3697	11.1792
430057	15.1516	15.4390	17.2805	15.9601
430060	8.6409	9.0358	10.0176	9.2343
430062	10.8879	*	*	10.8879
430064	12.7394	14.4367	14.2184	13.7779
430065	12.7660	*	*	12.7660
430066	13.4380	14.3557	15.6660	14.4524
430073	14.9784	16.1133	15.3776	15.4839
430076	12.2452	12.7608	13.9883	12.9521
430077	17.7126	19.3012	19.8558	18.9586
430079	12.9780	13.6836	14.1815	13.5924
430087	10.4491	*	*	10.4491
430089	17.0065	17.8908	17.9790	17.6658
430090	*	21.5239	21.5974	21.5592
430091	*	19.2146	18.1567	18.5152
430092	*	*	21.3807	21.3807
430093	*	*	19.5013	19.5013
440001	15.3134	14.8713	15.5897	15.2550
440002	18.5411	19.1498	20.3740	19.3756
440003	17.4736	18.3658	19.3042	18.3967
440006	20.6559	19.6021	21.4055	20.5221
440007	7.7632	12.1230	14.8959	11.0241
440008	15.4701	17.2848	18.8994	17.1822
440009	15.4558	17.8424	17.4831	16.9676
440010	13.5118	19.9829	16.3283	16.4644
440011	17.1591	17.6948	18.3375	17.7161
440012	19.0606	15.9837	19.5739	18.2503
440014	14.6093	15.9195	16.1143	15.5705
440015	21.0884	18.2632	22.0659	20.4116
440016	14.9409	15.4097	16.2964	15.5583
440017	21.1258	19.6215	20.4563	20.3835

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
440018	18.2080	16.4115	17.4995	17.3550
440019	28.2242	20.0416	21.5402	22.7883
440020	15.5889	18.1154	17.8879	17.2181
440022	19.0214	15.8459	*	17.5909
440023	14.1410	15.4721	16.7837	15.4038
440024	18.1028	18.4432	18.4046	18.3183
440025	15.2826	15.8784	16.3140	15.8395
440026	22.9174	23.0550	23.2566	23.0549
440029	18.5183	19.4326	20.7050	19.5797
440030	15.5718	16.2941	16.9925	16.3267
440031	14.3023	15.5432	17.0211	15.6197
440032	13.5996	13.9775	13.8140	13.7931
440033	14.0409	14.5304	13.7328	14.1227
440034	17.9315	19.5470	20.0309	19.2030
440035	18.1578	18.9026	19.3034	18.7862
440039	19.3747	19.9439	21.6536	20.3424
440040	17.4965	16.3740	16.9275	16.9214
440041	13.6279	14.6621	14.9545	14.4249
440046	16.8798	18.1654	19.3229	18.0984
440047	17.0037	16.6646	17.8092	17.1528
440048	18.1449	19.4498	21.4993	19.5981
440049	16.7066	17.9292	18.7967	17.8439
440050	16.7627	19.1328	18.2511	18.0098
440051	14.9074	13.1901	16.0421	14.6532
440052	16.2693	16.6541	19.8075	17.4207
440053	17.6873	18.5515	19.6494	18.6583
440054	12.3134	13.8716	13.3967	13.1942
440056	14.2534	15.9821	16.2742	15.4778
440057	12.7190	12.7925	13.7257	13.0446
440058	18.7381	18.8118	19.1878	18.9185
440059	17.5274	18.5418	19.6018	18.6049
440060	15.8599	18.0586	19.7916	17.7309
440061	16.8442	14.9708	22.5525	17.8114
440063	18.2923	19.3222	19.8371	19.1661
440064	17.6154	17.7652	18.9809	18.1133
440065	18.6943	18.5825	18.8296	18.7013
440067	22.0655	16.2811	17.2397	18.2348
440068	17.4513	19.4695	19.3668	18.7087
440070	15.0440	13.7035	14.0437	14.2715
440071	16.2691	17.0186	19.7836	17.5412
440072	16.7675	17.5995	19.1522	17.8026
440073	18.5576	19.1714	19.5554	19.1079
440078	13.0916	15.0849	16.0188	14.6728
440081	17.9702	18.3587	19.3454	18.5764
440082	23.0805	22.2857	22.6855	22.6613
440083	35.0978	14.8525	13.7423	17.4998
440084	13.3678	13.4378	13.7731	13.5305
440091	19.7250	19.6114	20.1065	19.8343
440100	13.9487	13.8437	14.7113	14.1637
440102	13.9575	14.3510	14.5500	14.2949
440103	19.2083	20.3052	18.6990	19.3857
440104	22.3883	22.4403	22.6754	22.4883
440105	16.0338	16.7131	17.1172	16.6050
440109	14.2491	16.0446	17.7443	15.8919
440110	15.9174	21.1716	17.4816	17.9016
440111	21.0682	23.2425	23.2254	22.5309
440114	13.6095	14.4997	15.0036	14.3318
440115	12.9668	17.4514	18.5457	16.2205
440120	18.2993	17.2384	16.3115	17.2831
440125	16.1067	15.6588	19.4115	17.0424
440130	16.6750	17.8223	17.4857	17.3264
440131	14.6752	15.5048	16.1214	15.4186
440132	15.9069	16.6553	16.8871	16.4950

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
440133	21.5116	21.5313	23.0891	22.0182
440135	20.9029	19.2010	22.2005	20.8180
440137	14.6966	14.5632	15.0070	14.7511
440141	12.4774	13.5308	15.9429	13.7977
440142	13.0059	15.7287	16.8855	15.0859
440143	17.8429	17.7821	18.2061	17.9416
440144	16.6666	17.6415	18.3859	17.5674
440145	13.6577	17.0608	18.3948	16.1716
440147	22.0069	21.4304	26.1464	23.0399
440148	17.6438	19.2435	19.4598	18.7842
440149	17.1496	16.6923	18.4281	17.4374
440150	13.0775	20.1411	20.3006	17.2935
440151	15.4250	17.4248	18.3928	17.0781
440152	17.8399	21.0287	22.7664	20.2196
440153	16.0954	16.7769	16.5716	16.4916
440156	19.6117	29.5557	21.7577	23.1575
440157	11.3982	16.9265	18.4249	15.5384
440159	17.6237	17.7158	20.9371	18.4872
440161	20.7643	21.8013	22.8816	21.7855
440162	14.4121	14.7637	15.5534	14.8623
440166	18.1413	19.6684	19.2159	18.9985
440168	15.9513	18.6535	19.1509	17.9995
440173	18.4683	18.6402	19.1812	18.7699
440174	17.0080	17.3294	18.0865	17.4583
440175	17.6107	20.0802	18.5186	18.7356
440176	18.7529	18.0294	19.2208	18.6470
440180	17.3412	19.7773	20.2184	19.1376
440181	11.8471	16.4878	17.7709	15.0662
440182	20.3202	17.7487	19.7094	19.1341
440183	19.4374	22.7067	21.3465	21.1277
440184	18.0603	17.2037	16.8880	17.4646
440185	18.7286	19.3870	21.2188	19.7784
440186	18.5312	19.3948	19.7983	19.2465
440187	16.2530	18.9713	17.5872	17.6013
440189	16.1906	*	18.5252	17.4309
440192	19.9669	19.0839	19.1705	19.3968
440193	18.3952	19.0811	18.6999	18.7380
440194	20.3343	19.8682	22.4562	20.9277
440197	23.1080	21.9618	21.8503	22.2548
440200	16.0619	17.9575	19.8078	18.0280
440203	16.6132	18.3400	16.2861	17.0710
440206	15.5462	16.4429	*	16.0270
440209	14.7466	*	*	14.7466
440210	12.3292	11.0218	11.9815	11.7402
440211	*	14.8972	*	14.8972
440212	*	17.0685	*	17.0685
440213	*	19.5760	*	19.5760
440214	*	*	28.0285	28.0285
440215	*	*	22.2928	22.2928
450002	19.9195	21.3749	21.4836	20.9147
450004	15.2751	16.6723	16.7850	16.2360
450005	15.5888	18.3600	16.6396	16.8103
450007	15.7536	16.9681	19.1910	17.3218
450008	15.7458	17.0832	17.6582	16.7901
450010	16.0790	16.5001	17.6677	17.0234
450011	18.0137	17.1942	20.8102	18.6782
450014	18.2173	17.9495	17.5815	17.9004
450015	18.4400	18.9895	21.6773	19.6131
450016	17.3054	18.4463	18.3456	18.0337
450018	20.4133	21.4788	23.2293	21.6061
450020	16.9661	17.8415	19.1153	18.0122
450021	22.6910	23.0843	23.3630	23.0474
450023	16.6408	16.0831	17.6360	16.7896

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450024	16.5604	17.3518	18.5985	17.4846
450025	16.4396	17.0004	*	16.7280
450028	18.4287	18.8764	19.1658	18.8489
450029	17.6909	17.4716	17.7425	17.6360
450031	20.8992	22.2222	29.6945	23.8280
450032	15.2404	17.3317	14.6530	15.6504
450033	20.8634	19.7437	21.0222	20.5422
450034	18.9068	19.6721	18.8823	19.1560
450035	16.8132	20.0951	20.3599	19.0234
450037	18.6549	19.5411	19.9140	19.3829
450039	22.0811	19.8143	19.7176	20.5536
450040	17.5179	16.8534	19.6370	18.0669
450042	17.5906	19.8921	18.8357	18.7392
450044	21.0399	24.7961	21.0909	22.1921
450046	17.0917	18.6536	17.3631	17.6586
450047	13.9022	13.4486	16.9028	14.6102
450050	13.0037	14.7669	17.7209	15.0293
450051	20.0763	21.0236	21.1008	20.7301
450052	13.5278	13.8881	15.5890	14.3570
450053	17.3139	17.0467	17.2781	17.2160
450054	21.9835	22.8960	15.9388	20.5562
450055	14.8119	15.0433	15.8526	15.2415
450056	20.0008	21.8436	21.8605	21.2529
450058	16.9832	18.0967	18.6172	17.9075
450059	14.2072	15.2168	19.8240	16.2886
450063	13.8126	14.3815	12.7211	13.5914
450064	16.4165	17.4093	19.7682	17.8341
450065	19.6087	21.4934	23.3797	21.3723
450068	22.6924	22.8998	23.3495	22.9910
450072	17.3794	19.0111	18.0307	18.1442
450073	16.6168	17.1002	16.5942	16.7690
450078	13.4875	11.7265	13.2820	12.8188
450079	19.4899	21.0518	20.6483	20.4464
450080	16.3147	17.4553	18.6212	17.4805
450081	16.1653	16.3448	17.5737	16.7023
450082	13.2952	16.1585	16.8677	15.5279
450083	20.1830	21.5884	23.3754	21.7298
450085	14.2167	18.3602	20.0085	17.2728
450087	21.4764	22.0273	21.9320	21.8111
450090	13.9101	15.0939	15.5796	14.8590
450092	15.7316	16.8260	17.9520	16.8805
450094	19.4249	21.3158	23.2863	21.3961
450096	16.6300	17.8813	18.6802	17.7158
450097	18.2740	19.5723	19.7187	19.2252
450098	15.4796	20.5754	19.0454	18.3431
450099	22.8834	19.2258	20.4181	20.6312
450101	16.9628	17.1330	17.7928	17.2860
450102	18.8465	18.6707	19.8793	19.1269
450104	15.9781	16.6744	17.0821	16.5911
450107	20.7359	25.1986	24.1094	23.2223
450108	16.1451	15.6324	15.2797	15.6413
450109	12.7654	13.8127	10.5973	12.1326
450110	21.4421	19.5821	*	20.4354
450111	19.2749	19.6350	21.4908	20.1993
450112	14.7610	16.0441	18.1026	16.3114
450113	18.5356	20.9777	20.8306	19.9901
450118	15.8317	17.9053	*	16.9195
450119	18.3166	20.2853	20.2030	19.6520
450121	18.2278	20.4641	21.9198	20.1751
450123	19.1912	15.7618	14.1755	16.0237
450124	21.0925	22.7480	22.5208	22.1327
450126	17.4512	21.7233	21.4789	19.9557
450128	15.8881	18.2184	18.1446	17.4552

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450130	17.8722	20.4156	18.9211	19.0565
450131	17.6163	19.2589	17.4168	18.0711
450132	18.0745	18.1713	21.8089	19.3784
450133	19.9259	23.6366	26.0763	23.0339
450135	20.8065	21.0306	20.4068	20.7284
450137	23.9555	22.4590	23.4346	23.2829
450140	18.0743	20.2280	17.3370	18.5682
450143	14.4623	14.5270	15.0871	14.7298
450144	16.3037	18.1121	17.4309	17.3356
450145	14.8441	15.6078	16.1895	15.5356
450146	14.2041	17.8572	15.5030	15.8115
450147	18.0664	18.9363	19.0477	18.6958
450148	22.0269	18.6758	20.4923	20.3406
450149	24.0005	19.7521	21.7219	21.7182
450150	15.2061	16.3719	17.8612	16.4235
450151	14.8373	15.2906	16.4209	15.5098
450152	17.3780	18.0061	17.7265	17.7015
450153	19.9447	19.4419	18.6514	19.3436
450154	13.1810	13.8731	13.9119	13.6623
450155	23.7678	11.5841	13.3456	14.7760
450157	14.6623	15.6371	15.3083	15.2158
450160	8.7503	16.6533	10.6852	11.1452
450162	22.1981	20.9560	21.9218	21.6852
450163	16.9811	17.5403	17.8028	17.4591
450164	20.0368	16.9741	17.7180	18.0843
450165	15.1561	13.9218	17.3283	15.3582
450166	10.2801	11.4772	11.0541	10.9545
450169	15.8793	13.1990	*	14.1674
450170	14.8131	14.2997	14.3234	14.4821
450176	16.3031	16.9674	17.2576	16.8653
450177	14.7280	14.9241	15.2419	14.9812
450178	16.7550	17.8508	16.0280	16.8828
450181	14.0192	15.5622	18.6936	16.1716
450184	19.9674	21.1263	20.0821	20.3949
450185	13.0632	14.0714	11.5228	12.7662
450187	17.5702	16.6945	18.5053	17.5863
450188	13.7757	14.3938	15.1954	14.4624
450191	18.8023	20.1222	20.9512	19.9757
450192	19.3352	20.3795	21.2497	20.3207
450193	22.7325	23.1963	23.1639	23.0345
450194	19.1466	20.5187	20.7745	20.1569
450196	16.4929	17.1955	17.8993	17.1933
450200	17.3756	18.7387	19.2228	18.4203
450201	17.0548	16.9908	17.1463	17.0668
450203	18.6552	20.6712	19.3978	19.6025
450209	18.6566	19.0811	20.0140	19.2218
450210	14.2317	13.9758	16.3470	14.7958
450211	17.1433	17.9857	18.8114	17.9863
450213	18.4472	17.7631	19.0651	18.4304
450214	17.2465	19.0475	20.5070	18.8579
450217	11.6893	12.8457	12.7647	12.4509
450219	15.4207	15.3976	17.6884	16.1962
450221	16.9935	16.3700	15.2120	16.1091
450222	18.4542	20.3129	19.8967	19.5439
450224	22.8300	24.9046	20.1579	22.3861
450229	16.4116	16.4503	16.7853	16.5551
450231	17.7045	19.1564	19.1746	18.9853
450234	13.3012	16.1945	16.3003	15.4055
450235	13.4177	15.2332	16.3115	15.0648
450236	15.6774	16.6703	16.4957	16.3054
450237	17.3984	20.7930	19.0325	19.0438
450239	13.6376	17.1308	17.8401	16.0311
450241	14.8674	12.5675	16.4240	14.4148

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450243	12.3626	11.9099	13.6416	12.6485
450246	17.9702	16.5478	16.7959	17.0548
450249	11.6279	12.0302	11.7658	11.8055
450250	14.9133	10.2844	13.6787	12.3052
450253	15.3542	12.2402	13.2177	13.4392
450258	13.2334	16.0466	16.7337	15.4196
450259	17.8488	*	*	17.8488
450264	13.8879	13.8929	14.5956	14.1447
450269	14.9334	12.3594	12.7717	13.2360
450270	12.7018	12.8381	14.4792	13.2703
450271	15.4998	16.6319	16.7831	16.3572
450272	17.9514	19.9331	18.4344	18.7713
450276	12.7053	13.1155	14.0745	13.3159
450278	13.7894	14.8291	15.2950	14.5985
450280	19.4926	22.2984	22.2936	21.3667
450283	13.8916	14.5664	15.1950	14.5306
450286	12.1212	*	*	12.1212
450288	15.9878	16.2502	18.8935	16.9454
450289	18.3478	20.3104	20.3460	19.6703
450292	19.5050	16.9693	20.5335	18.8754
450293	14.4281	16.0132	16.2721	15.6074
450296	20.6628	21.6000	22.3430	21.5410
450299	17.9678	21.5672	*	19.7778
450303	12.6720	12.4582	12.8996	12.6812
450306	13.3165	13.8216	14.2047	13.8205
450307	16.6779	16.4622	17.0691	16.7424
450309	16.2055	13.1480	13.3771	14.0877
450315	20.8043	22.8140	21.4684	21.6913
450320	19.6331	20.0946	20.6596	20.1159
450321	13.3932	13.1752	14.7344	13.7774
450322	12.4570	22.7667	29.1884	20.6852
450324	17.8697	17.7886	19.1692	18.2493
450327	16.0935	11.7511	13.3639	13.4001
450330	18.4163	18.9425	19.8066	19.0827
450334	12.2721	12.8051	13.8392	12.9835
450337	17.4208	17.1073	25.5708	18.8965
450340	15.8519	17.6914	*	16.7663
450341	19.1828	18.9429	*	19.0666
450346	17.1038	17.5367	18.9475	17.8083
450347	17.6908	17.1099	19.3475	18.0306
450348	12.9414	13.9535	13.3585	13.4272
450351	15.9772	18.4116	19.3159	17.9591
450352	17.8528	18.7480	20.1871	18.9532
450353	15.0020	17.7539	16.0003	16.2513
450355	14.3182	11.9473	11.8933	12.5966
450358	21.2812	22.3235	23.0206	22.2174
450362	15.3536	15.8847	18.1983	16.4730
450369	15.1854	15.2233	15.3122	15.2420
450370	15.4368	12.6061	16.1369	14.6391
450371	11.8996	24.6339	16.0236	16.3341
450372	19.8589	20.0924	22.0746	20.6261
450373	17.5998	17.4183	17.9554	17.6614
450374	12.8264	13.6099	15.1750	13.8338
450378	23.1598	23.5789	23.4599	23.4221
450379	20.2756	22.7632	22.8756	21.9542
450381	15.6215	16.4166	16.7112	16.2538
450388	17.5561	19.2499	19.7408	18.8527
450389	18.1478	18.1797	18.8448	18.4036
450393	18.7387	20.2784	22.4992	20.3300
450395	16.6754	18.3768	18.0024	17.6923
450399	16.3066	15.7845	15.3491	15.8113
450400	14.0761	19.5379	18.6668	17.2665
450403	21.3691	20.1989	22.8430	21.4973

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450411	14.0463	14.4832	15.1121	14.5493
450417	13.8517	13.4983	15.3591	14.2291
450418	20.5847	21.9161	21.9690	21.5007
450419	21.8196	20.6325	23.2551	21.9114
450422	24.5309	26.4848	28.0257	26.2815
450423	19.4352	22.7132	*	20.9607
450424	17.5658	18.9741	18.7895	18.4852
450429	11.3811	13.8723	*	12.4654
450431	16.2696	19.6304	22.0361	19.0606
450438	16.5461	19.5028	15.4553	17.0919
450446	21.9685	13.0986	20.7592	18.0346
450447	16.6124	18.0376	18.0377	17.5317
450451	19.6424	18.8948	18.2988	18.9126
450457	19.7689	24.7880	19.6569	21.1382
450460	14.2156	15.1765	14.6523	14.6666
450462	20.1347	22.6212	22.1144	21.6206
450464	13.4714	13.2931	15.5908	14.0563
450465	15.2203	15.5650	15.4731	15.4326
450467	15.6034	10.6184	17.0004	13.7745
450469	22.1012	19.6269	22.1930	21.2351
450473	14.1895	19.9761	19.7148	17.9827
450475	16.2489	16.3404	16.9269	16.5089
450484	19.5869	16.8131	18.9825	18.4097
450488	18.6813	19.3457	19.2173	19.0899
450489	14.5747	9.9326	16.3584	13.1235
450497	11.9242	15.0886	16.2997	14.3957
450498	12.0249	13.8551	14.4713	13.5076
450508	19.8722	18.8069	19.0991	19.2442
450514	22.2791	21.3243	20.0144	21.2387
450517	12.8702	27.8815	14.3191	16.6822
450518	19.0112	19.8116	21.4873	20.0415
450523	20.2589	20.0792	21.0393	20.4436
450530	22.9101	22.8623	21.1634	22.2676
450534	24.0835	19.9376	20.1520	21.2600
450535	21.2659	19.6645	21.0513	20.6461
450537	21.7432	20.8438	20.1161	20.8690
450538	19.6864	*	*	19.6864
450539	14.2536	16.4921	18.7559	16.5056
450544	19.3848	23.9283	23.6652	21.9211
450545	16.9674	19.5558	20.2823	18.9428
450547	13.8074	14.8248	18.1524	15.7208
450551	13.9069	16.9439	16.6237	15.8128
450558	20.0164	22.2574	20.7404	21.0120
450559	13.4572	*	*	13.4572
450561	16.8162	*	*	16.8162
450563	30.3744	19.9218	22.0708	22.9095
450565	16.4545	16.2652	17.3803	16.7063
450570	17.7135	18.9532	19.0336	18.5591
450571	16.9705	17.5598	18.2784	17.6264
450573	15.6698	12.2502	17.3518	14.9746
450574	14.2411	14.5965	14.6128	14.4845
450575	19.0613	19.3925	22.5621	20.3955
450578	16.8731	15.4783	18.0925	16.7620
450580	15.3581	15.8321	16.7374	16.0231
450583	15.5040	15.6580	14.4411	15.1895
450584	13.3747	14.2321	14.6735	14.1004
450586	12.8439	14.3773	13.8248	13.7154
450587	17.1124	17.0230	18.0219	17.3661
450591	17.9151	17.8981	17.7795	17.8608
450596	14.8232	22.5420	21.6729	19.1117
450597	16.1797	17.0776	17.6179	16.9806
450603	12.7682	11.6442	23.5572	15.3844
450604	15.4790	16.4535	17.6582	16.5641

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450605	20.1541	21.1400	19.4580	20.2362
450609	10.7323	15.9753	17.0986	14.6244
450610	16.7464	18.9924	21.5191	19.2633
450614	13.8304	17.9853	16.5754	15.9153
450615	14.7457	14.8562	15.2956	14.9778
450617	19.5381	20.3387	20.8919	20.3006
450620	13.7063	15.8380	16.0987	15.2421
450623	21.8275	22.1950	23.1270	22.3514
450626	19.7896	18.1673	18.4349	18.7617
450628	16.8345	20.5611	18.6093	18.6475
450630	19.1904	21.6876	20.9605	20.5728
450631	17.5555	20.0417	21.6736	19.4992
450632	12.7295	11.7587	13.9147	12.7814
450633	20.7209	19.5183	19.4949	19.8926
450634	20.2932	23.5333	22.9877	22.3295
450638	19.6968	23.1437	22.1704	21.6228
450639	20.3050	23.1936	21.6421	21.6608
450641	13.5049	16.5125	15.7578	15.1652
450643	17.4268	18.7054	16.8152	17.6481
450644	20.7904	23.6587	22.7721	22.2903
450646	19.9866	19.8274	19.1433	19.6406
450647	22.4196	24.7981	24.2763	23.8588
450648	14.7541	14.8488	15.0305	14.8793
450649	15.8156	16.4496	16.6577	16.3245
450651	20.7304	22.7664	22.7112	22.1063
450652	16.6461	13.4389	17.2445	15.4912
450653	19.2847	18.1834	19.2349	18.8580
450654	13.8833	14.5258	14.5423	14.3223
450656	18.7328	17.6723	18.2606	18.1968
450658	15.1477	16.2657	17.2630	16.2787
450659	20.5609	22.2550	23.0108	21.9106
450661	20.2196	19.7160	18.9071	19.5857
450662	18.6797	18.2284	19.3152	18.7697
450665	15.4395	15.2015	16.1319	15.5906
450666	19.3456	20.3248	20.2549	19.9584
450668	18.7218	20.6965	21.0972	20.1590
450669	22.2832	21.7632	21.6746	21.8862
450670	18.2030	16.8893	20.2632	18.5133
450672	21.2079	21.8559	21.4927	21.5115
450673	13.8444	13.9620	13.7005	13.8283
450674	20.6151	22.2796	22.2426	21.7353
450675	23.2587	22.4961	21.4479	22.2858
450677	18.7905	22.6839	20.6556	20.7200
450678	20.7453	23.2617	24.1301	22.6596
450683	21.1748	20.9143	22.8699	21.6172
450684	22.8552	19.7005	21.9962	21.3850
450686	15.0122	16.5661	16.4632	15.9861
450688	20.8988	19.6250	20.1831	20.2348
450690	22.4118	21.6578	22.4707	22.1725
450694	18.4917	17.4758	18.1872	18.0283
450696	17.5701	24.9636	*	21.1885
450697	15.9259	18.8405	19.4949	18.0008
450698	14.3983	14.6680	15.4750	14.8475
450700	15.1153	14.6421	15.9050	15.2506
450702	21.0157	20.8223	21.3739	21.0706
450703	18.8029	*	*	18.8029
450704	21.6236	20.9821	20.7987	21.1724
450705	22.3175	30.0116	22.1809	24.2035
450706	21.3777	21.2072	22.0884	21.5769
450709	19.7741	20.8889	22.1490	21.0078
450711	18.2350	19.8126	19.8581	19.3268
450712	16.8942	13.6240	15.9298	15.4007
450713	23.6009	20.8065	22.6986	22.2836

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
450715	19.7719	22.0413	22.5988	21.5504
450716	19.9871	20.5544	20.9074	20.4812
450717	19.4546	20.7192	20.6551	20.2618
450718	19.0679	19.6886	22.1765	20.3069
450723	19.7044	19.7563	20.8213	20.1083
450724	20.0667	20.3235	20.3706	20.2569
450725	19.5572	*	*	19.5572
450727	17.7508	13.5458	17.9172	16.1802
450728	12.9277	17.5284	19.8879	16.6493
450730	20.9129	22.0819	23.0054	22.0459
450733	20.3718	20.7693	20.2199	20.4645
450735	8.0014	13.8767	*	10.0108
450742	20.7775	22.7655	21.8392	21.8145
450743	15.9493	18.8937	19.6015	18.1561
450746	20.7534	12.7904	30.2657	19.9075
450747	17.3842	19.2585	20.3914	18.9599
450749	12.9542	16.2130	19.1678	16.2656
450750	14.7207	14.6914	13.8098	14.4310
450751	22.2491	21.2198	19.9995	21.3756
450754	14.8896	16.0860	16.7145	15.9455
450755	14.7070	17.9904	19.8743	17.5601
450757	13.9636	13.8675	14.9434	14.2422
450758	18.6513	21.8669	19.0221	19.8347
450760	18.0690	17.4852	19.2225	18.2582
450761	11.1444	13.6152	15.7681	13.3382
450763	17.5603	18.2123	18.6092	18.1083
450766	21.8103	22.4348	23.3879	22.5926
450769	13.6183	14.5858	18.4163	15.2554
450770	16.8250	16.5458	19.0183	17.4436
450771	21.5814	22.4542	21.8268	21.9636
450774	16.5198	17.9964	16.2948	16.9482
450775	19.9651	19.8897	21.3504	20.4169
450776	10.1953	15.7750	14.1720	13.1591
450777	19.5923	21.0682	19.0380	19.9747
450779	22.9697	21.4546	21.6642	21.8768
450780	15.2800	19.1498	19.0914	17.6291
450785	18.5475	18.4976	*	18.5211
450788	20.9806	19.1463	19.6469	19.7295
450794	18.3981	18.2229	*	18.3485
450795	14.1682	16.6494	22.5753	17.9737
450796	17.4472	16.5362	19.2059	17.6627
450797	18.5901	15.9188	16.4923	16.8594
450798	9.2165	9.4634	*	9.3327
450801	16.6095	17.5669	17.9548	17.3668
450802	18.9018	19.9168	17.1435	18.5477
450803	16.2047	18.3767	21.6653	19.3492
450804	20.2223	19.4846	19.0893	19.5891
450807	13.2256	11.3192	13.4306	12.5547
450808	45.4728	16.9915	17.4917	21.1577
450809	19.0266	20.0202	19.7899	19.6416
450811	18.3847	19.0961	19.9168	19.1389
450812	20.7383	*	*	20.7383
450813	*	15.9166	14.5392	15.1549
450815	*	*	21.2741	21.2741
450819	*	*	16.5521	16.5521
450820	*	*	26.8348	26.8348
450822	*	*	22.8556	22.8556
460001	20.6336	21.7996	22.2735	21.5846
460003	20.5958	20.0452	22.6289	21.0329
460004	20.8196	21.3744	21.7234	21.3231
460005	17.5818	19.7069	22.5252	19.8732
460006	19.6485	20.6252	21.0700	20.4918
460007	20.5677	20.8026	21.1922	20.8840

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
460008	21.0338	18.8661	19.1153	19.6864
460009	21.1084	21.9016	22.5295	21.8515
460010	21.2473	21.9830	22.4948	21.9354
460011	16.7114	18.8660	19.7674	18.3702
460013	20.3331	20.7326	20.1936	20.4306
460014	19.5465	18.3865	18.5370	18.7488
460015	20.0987	20.6593	21.0470	20.6197
460016	18.0791	18.2408	21.9105	19.2998
460017	26.0310	17.7103	18.9929	19.9984
460018	16.8566	17.6235	17.0063	17.1606
460019	17.3683	16.2671	17.8690	17.1417
460020	17.0271	17.3467	17.2663	17.2239
460021	20.2613	21.0470	21.5174	20.9913
460022	18.2100	20.1534	21.3614	19.7210
460023	21.3321	22.3535	22.9265	22.2381
460024	13.0279	*	*	13.0279
460025	12.5083	19.4247	17.3494	16.5301
460026	17.3431	19.9241	20.2576	19.0202
460027	20.8331	21.8868	22.2955	21.6637
460029	17.2501	20.5154	20.8366	19.2190
460030	17.2196	17.6071	17.1383	17.3160
460032	19.5474	21.1006	21.4832	20.7171
460033	15.7233	19.5372	19.2664	18.1972
460035	14.2802	16.0021	16.1685	15.4874
460036	22.3788	23.5893	23.4573	23.1384
460037	18.7665	18.6850	17.7399	18.3920
460039	24.4781	24.9134	24.4808	24.6217
460041	21.6926	21.0623	20.2035	20.9715
460042	17.8455	18.8814	19.5662	18.7473
460043	23.8970	24.4779	23.2819	23.8380
460044	20.6897	21.4696	21.8485	21.3516
460046	17.1085	18.2224	*	17.6742
460047	21.3843	23.0433	22.7524	22.4777
460049	18.8206	19.6483	20.8283	19.8892
460050	26.2485	*	*	26.2485
460051	20.9797	19.4761	22.1758	20.8643
460052	*	*	19.8961	19.8961
470001	19.6108	20.2299	21.3817	20.4021
470003	22.5949	23.6949	22.0563	22.7712
470004	18.0952	16.8842	18.1879	17.7051
470005	21.5151	21.9191	23.1808	22.1962
470006	18.3898	17.8699	20.2829	18.8123
470008	19.4136	19.6069	20.1969	19.7378
470010	19.4652	20.2961	21.0616	20.2790
470011	21.2014	21.7675	22.2415	21.7386
470012	18.5162	18.5339	18.9444	18.6579
470015	19.2552	19.5366	20.2125	19.6399
470018	20.4161	21.5426	21.2406	21.0610
470020	18.9884	20.6643	21.5688	20.4558
470023	20.6391	20.4511	21.7139	20.9439
470024	20.4087	20.8510	21.9807	21.0777
490001	24.7604	21.9755	20.0570	22.0422
490002	12.9871	15.2287	15.7365	14.6222
490003	18.0034	19.1040	20.3237	19.1299
490004	18.7731	19.2126	19.7074	19.2382
490005	16.9087	20.5517	21.3318	19.6257
490006	15.2276	15.9537	12.3253	14.5928
490007	18.4330	18.7740	19.8938	19.0586
490009	22.9513	23.9344	23.7659	23.5499
490010	18.5780	21.7424	*	19.9381
490011	18.7508	18.6071	19.8042	19.0282
490012	13.7788	15.9973	15.2965	15.0022
490013	16.9324	17.3318	18.2396	17.5085

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
490014	24.5557	25.8315	23.5266	24.6242
490015	19.3608	19.6363	20.0667	19.6821
490017	17.3152	18.4361	19.3854	18.3964
490018	17.9433	18.3435	18.5508	18.2858
490019	17.5309	19.6178	21.0124	19.4215
490020	17.6655	18.5691	19.3424	18.5533
490021	19.4490	19.3945	20.0496	19.6794
490022	20.7223	21.2183	22.3380	21.4351
490023	18.9587	20.6694	21.5683	20.4224
490024	16.8904	17.7221	18.4314	17.8400
490027	14.4234	16.2761	16.7556	15.8360
490030	10.5029	9.1789	8.6446	9.5559
490031	15.8213	14.9539	16.0003	15.5875
490032	21.5592	22.4262	21.4037	21.7854
490033	18.3265	21.1723	19.2908	19.5511
490037	15.9704	16.3759	17.0113	16.4399
490038	15.7099	21.0218	17.6324	17.9048
490040	22.5237	22.7061	24.1266	23.1321
490041	16.5542	18.3589	18.7987	17.8901
490042	15.2717	16.4666	17.0972	16.2668
490043	20.6775	22.1574	22.1068	21.7221
490044	17.6282	18.3137	19.7842	18.6148
490045	19.6325	20.5468	20.5558	20.2593
490046	18.6112	18.4825	19.9102	19.0232
490047	17.1631	25.0438	18.7614	19.8637
490048	17.8907	18.4361	19.5417	18.6005
490050	22.7129	23.0729	23.3668	23.0530
490052	16.9363	16.8600	16.4787	16.7609
490053	15.6883	15.6996	16.8410	16.1062
490054	15.5516	15.4734	19.5780	16.7024
490057	19.0668	19.9210	20.3160	19.7770
490059	20.3744	20.8662	21.4801	20.8999
490060	19.2006	17.6308	18.5917	18.4363
490063	28.2527	28.6536	26.1930	27.6341
490066	16.5024	20.6972	19.8352	18.9146
490067	17.1922	17.0195	17.8487	17.3549
490069	15.6986	17.3297	20.7582	17.8379
490071	19.4701	21.8879	23.3511	21.4480
490073	26.1420	20.7960	26.0957	24.1488
490074	19.3417	*	*	19.3417
490075	19.1906	18.6983	19.2156	19.0267
490077	19.7866	21.3670	22.6504	21.2469
490079	16.4379	17.0815	17.7016	17.0749
490083	16.6406	*	*	16.6406
490084	16.3846	16.7834	18.0555	17.0646
490085	16.3979	17.4584	17.6158	17.1539
490088	15.5982	16.4362	17.9141	16.6068
490089	15.8618	17.7692	18.2290	17.2642
490090	16.2785	17.0199	17.5799	16.9734
490091	19.9949	20.8734	25.0272	21.8088
490092	15.6893	16.9533	16.4360	16.3528
490093	16.4767	17.3711	17.8275	17.2502
490094	16.7880	18.9204	22.3033	19.3562
490095	18.2495	*	*	18.2495
490097	15.8586	15.5780	16.9518	16.0789
490098	14.6971	15.1403	16.0488	15.2544
490099	16.8667	17.9665	18.3985	17.7293
490100	17.2189	22.5010	*	19.8823
490101	25.0907	24.7616	23.5553	24.4275
490104	28.4910	25.6889	40.2529	29.2590
490105	18.2461	18.5765	21.4428	19.2491
490106	16.9117	17.6596	26.3821	18.9838
490107	22.4054	23.5240	22.9283	22.9660

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
490108	19.7478	20.2112	24.1232	21.0559
490109	21.1589	23.6620	25.9475	23.4402
490110	15.8408	16.5131	18.1561	16.8181
490111	17.3453	17.1768	17.8510	17.4580
490112	20.5239	21.4532	22.1162	21.3613
490113	23.0840	23.2235	23.9043	23.4071
490114	16.9083	17.3047	18.0359	17.4375
490115	17.1023	16.5203	16.8537	16.8239
490116	16.4436	16.6170	17.2040	16.7676
490117	13.8429	14.0104	14.7944	14.2244
490118	20.8707	21.4674	23.2022	21.8304
490119	17.8686	17.9147	18.6046	18.1353
490120	19.9810	19.3707	20.5777	19.9742
490122	23.9695	23.8801	23.8198	23.8925
490123	16.8505	17.7461	19.3056	18.0001
490124	19.3616	22.0884	21.3818	20.8857
490126	18.2276	18.6844	20.4294	19.0254
490127	14.4815	16.0516	16.5993	15.6547
490129	27.4701	22.5885	28.6868	25.1130
490130	16.2779	16.4322	17.6943	16.7915
490132	17.0204	18.6570	18.4671	18.0649
500001	21.3476	22.1896	24.4829	22.6367
500002	21.0375	21.6332	19.8476	20.7811
500003	24.3055	24.2814	24.4333	24.3392
500005	23.4808	22.3955	24.3870	23.3703
500007	22.4269	26.0599	21.9911	23.4148
500008	24.1930	25.3064	26.1737	25.2130
500011	25.1836	24.0162	24.6554	24.5938
500012	22.2815	20.7032	24.2799	22.3541
500014	23.9276	24.3419	24.0990	24.1249
500015	23.2435	23.9297	24.9923	24.0554
500016	23.9034	24.3938	24.9439	24.4287
500019	22.3668	22.4213	23.2054	22.6470
500021	24.4622	25.9198	27.6490	25.9957
500023	27.1892	26.6535	27.1025	26.9568
500024	24.0453	23.7472	26.6452	24.7736
500025	23.9557	26.4810	24.4825	24.9695
500026	23.3491	23.8005	26.9884	24.7238
500027	25.0529	22.2158	25.1125	24.0804
500028	18.8588	19.2675	18.9556	19.0337
500029	16.8083	17.9237	18.5042	17.7373
500030	24.1321	24.9039	26.3828	25.1714
500031	23.3659	29.2707	23.6099	25.1784
500033	21.3906	22.3527	22.5462	22.1428
500036	21.8950	22.1096	23.6333	22.5254
500037	19.6803	20.7139	21.4059	20.6062
500039	23.3211	23.8918	24.0007	23.7403
500041	24.8556	23.9608	25.4376	24.7549
500042	22.1286	22.9125	*	22.5386
500043	20.2509	20.9459	22.0466	21.0230
500044	23.1128	23.3364	24.2212	23.5535
500045	22.0982	20.8881	24.0526	22.2906
500048	19.3029	22.1906	20.3207	20.5960
500049	22.9534	24.0489	24.5997	23.8657
500050	20.9445	22.0065	22.6563	21.9092
500051	24.4769	24.8203	25.9447	25.1087
500053	22.0515	23.9397	22.8399	22.9429
500054	22.9024	22.8829	23.8089	23.1889
500055	22.8769	23.7446	23.8622	23.5097
500057	18.0424	18.2737	19.0479	18.4516
500058	23.3984	24.7882	24.1106	24.0962
500059	22.5412	23.3506	26.6270	24.1016
500060	23.5360	25.0233	28.3655	25.4628

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
500061	20.3957	21.7013	20.8624	20.9851
500062	19.4607	18.6329	19.0557	19.0333
500064	24.5283	25.5748	26.7000	25.6273
500065	21.4254	21.9308	23.5671	22.3106
500068	18.6960	19.6574	19.2638	19.2003
500069	20.6262	21.3592	21.4542	21.1522
500071	19.3810	19.1906	19.1428	19.2439
500072	24.4599	25.3928	25.2001	25.0228
500073	21.4303	21.2469	21.7698	21.4835
500074	18.6506	18.9679	19.5981	19.0849
500077	23.2056	22.8536	23.9410	23.3357
500079	22.9809	24.2036	23.1041	23.4248
500080	13.8000	15.6630	18.3883	15.5897
500084	22.2169	23.4032	24.4044	23.3798
500085	28.6121	21.4403	20.4517	22.7948
500086	22.3132	23.3288	22.8829	22.8469
500088	23.6988	23.2701	25.2478	24.0737
500089	17.9399	18.7080	19.7166	18.7736
500090	16.3297	16.1576	20.4429	17.2562
500092	17.2881	16.7913	19.2028	17.7527
500094	18.1080	18.5835	15.7866	17.6577
500096	20.9580	21.0151	23.3564	21.7716
500097	20.8010	19.7706	20.8774	20.4568
500098	12.9935	16.3511	15.2040	14.9340
500101	19.4498	19.7337	15.8000	18.3994
500102	20.3321	20.9389	21.8963	21.0615
500104	22.5849	22.8154	24.9389	23.3843
500106	18.7087	18.6041	19.1465	18.7914
500107	17.2987	18.1201	17.9489	17.8064
500108	27.2126	26.2939	28.6229	27.3944
500110	21.4053	21.4553	22.9775	21.9505
500118	22.9245	23.8397	24.8034	23.8697
500119	21.5704	22.4373	22.1192	22.0436
500122	21.9135	22.4268	23.5264	22.6230
500123	19.5855	20.3181	19.6646	19.8819
500124	24.1473	23.2836	23.7742	23.7287
500125	16.6272	15.1112	14.7910	15.5165
500129	23.5952	26.1575	25.4685	25.1115
500132	19.3567	15.6717	23.1822	19.3937
500134	20.9570	17.7457	17.2430	18.5700
500139	20.8816	22.2297	22.3053	21.8379
500141	22.9358	23.8838	29.9695	25.5485
500143	17.6031	18.0343	18.2570	17.9797
500146	17.8558	21.6003	*	19.6218
510001	17.8282	19.1492	20.0429	18.9855
510002	17.3409	20.1527	17.6392	18.3009
510005	14.4330	14.2503	13.8621	14.1872
510006	17.8821	18.7313	19.9609	18.8717
510007	20.2483	21.2729	21.6761	21.0848
510008	17.3653	18.3296	19.0513	18.2388
510012	16.5037	15.8390	15.6089	15.9887
510013	16.6194	17.8527	19.5798	17.9628
510015	14.7904	14.9039	16.7311	15.5193
510016	12.0276	*	*	12.0276
510018	16.4757	18.5269	18.5358	17.8403
510020	12.6472	13.1837	14.1211	13.3435
510022	19.8375	20.1763	21.5770	20.5146
510023	15.9417	16.0129	16.7777	16.2444
510024	18.7982	19.0941	18.7461	18.8794
510026	13.4586	13.6888	13.7952	13.6491
510027	17.5759	17.2900	18.5945	17.8135
510028	20.7306	20.0628	19.9208	20.2198
510029	17.0519	17.7124	18.4668	17.7625

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
510030	18.3137	17.4198	17.7603	17.8189
510031	18.4887	28.6673	18.6341	21.0020
510033	18.8061	18.4082	18.4718	18.5670
510035	18.6471	16.5007	18.3164	17.7425
510036	13.1995	13.4559	13.8786	13.5021
510038	14.3433	15.8132	15.5576	15.2710
510039	16.0555	16.9398	17.1461	16.7060
510043	14.2872	14.0662	13.1308	13.8129
510046	17.7320	17.3821	18.5896	17.9120
510047	19.1202	19.8963	20.8101	19.9042
510048	20.3734	21.0407	17.1647	19.5052
510050	16.5681	16.9136	18.4036	17.3154
510053	15.5856	16.1036	17.5798	16.4010
510055	22.8376	23.7248	24.2133	23.6043
510058	17.9786	18.4156	18.4501	18.2860
510059	16.7732	16.5854	16.1044	16.5068
510060	15.6581	17.5594	*	16.5969
510061	14.2227	13.8204	14.1968	14.0767
510062	17.6276	19.3881	18.1588	18.4173
510065	14.5882	*	*	14.5882
510066	12.7164	12.2943	*	12.5091
510067	18.1079	16.7161	17.3067	17.3634
510068	16.2864	18.7938	23.0452	19.1223
510070	16.3616	18.5146	18.7091	17.9505
510071	16.2390	17.2148	18.0278	17.1797
510072	17.6579	15.6262	15.9257	16.4174
510077	16.4111	18.0668	18.2947	17.6316
510080	14.7966	17.4485	16.3453	16.1690
510081	13.0020	13.6359	11.9701	12.8648
510082	13.6905	17.4538	13.5946	14.7307
510084	12.4820	17.2395	13.5339	14.4076
510085	18.6367	17.5624	18.6227	18.2581
510086	13.7937	13.4763	14.2241	13.8304
510088	*	*	14.8854	14.8854
520002	18.3521	19.7447	19.6755	19.2773
520003	16.4334	17.1248	18.7956	17.5028
520004	18.1744	19.6512	20.4591	19.4206
520006	20.4446	21.5313	21.4884	21.1400
520007	13.1087	16.2001	18.4629	16.0134
520008	22.8024	22.8024	24.9395	23.5372
520009	18.5094	18.6002	21.4638	19.4842
520010	20.3447	22.7703	22.3311	21.8215
520011	20.3797	20.7410	21.5223	20.8830
520013	21.6289	20.3965	20.5944	20.8585
520014	16.3989	17.1646	18.0841	17.1764
520015	18.3185	18.6078	19.7672	18.9031
520016	13.2889	17.3018	18.4320	16.1862
520017	19.3179	19.6008	19.4780	19.4685
520018	18.6441	21.1941	21.5279	20.5280
520019	18.3143	19.5440	20.9164	19.5698
520021	20.0355	21.3471	21.9531	21.1390
520024	14.6107	14.0175	14.4750	14.3609
520025	18.1086	18.2430	20.3838	18.8661
520026	19.8131	21.5453	20.8546	20.7335
520027	18.9085	19.9324	21.5868	20.1744
520028	19.1370	21.2852	22.5941	20.9020
520029	16.7520	19.5750	21.4197	19.2161
520030	20.0043	20.5039	21.6311	20.7089
520031	18.7066	20.4814	20.9875	19.9520
520032	17.9007	19.5697	21.1069	19.5434
520033	18.8906	19.2954	20.2520	19.4725
520034	16.6858	17.1282	20.4307	18.0336
520035	17.0997	18.9452	18.7135	18.2608

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
520037	20.0516	20.6686	21.6017	20.7624
520038	17.7074	19.6294	20.6130	19.3169
520039	19.5990	20.7641	23.3687	21.1069
520040	20.7420	20.4677	21.2023	20.8002
520041	15.3666	17.1959	18.4117	16.9517
520042	17.6577	18.5843	19.5466	18.6338
520044	17.7932	18.4014	19.1877	18.4535
520045	19.6736	20.5917	21.2427	20.5162
520047	17.8702	18.3048	20.3487	18.7633
520048	19.1712	20.6583	19.8926	19.9142
520049	19.5727	20.3559	20.1667	20.0444
520051	19.7416	21.6497	24.0460	21.7205
520053	16.4887	17.3945	18.0851	17.3336
520054	15.9873	15.1747	16.8363	15.9586
520057	18.3186	19.0872	19.8492	19.0812
520058	18.1264	19.7283	21.2500	19.7133
520059	19.8530	20.9913	21.5796	20.8254
520060	17.1675	17.9258	18.8232	17.9582
520062	17.8000	19.1482	19.7038	18.8681
520063	20.7744	19.6136	20.5262	20.3055
520064	21.4586	22.7423	22.0917	22.0917
520066	22.4419	22.8837	24.0087	23.0580
520068	18.0798	18.9943	19.6855	18.9053
520069	17.9133	20.2934	20.1770	19.3716
520070	17.8192	18.5938	19.4261	18.6155
520071	18.7861	18.7304	19.9866	19.1576
520074	18.6923	20.4601	20.9007	20.0036
520075	19.0891	19.8457	20.7301	19.8876
520076	16.5072	17.6088	19.5878	17.8567
520077	15.5427	17.7830	18.7119	17.3266
520078	20.5559	21.3380	21.7545	21.2404
520082	16.7417	17.7405	*	17.1848
520083	22.5715	23.8849	23.5787	23.3411
520084	18.9475	20.8427	23.5446	21.0737
520087	19.3942	20.3624	20.7821	20.1850
520088	20.1529	20.6312	21.8931	20.8632
520089	20.6110	21.5456	22.1055	21.4053
520090	18.0026	18.9343	20.3645	19.1272
520091	20.0693	20.9927	20.9440	20.6686
520092	17.5577	17.6500	18.6248	17.9402
520094	19.7791	20.3611	20.6179	20.2438
520095	18.5066	20.3269	18.6425	19.1370
520096	19.2980	19.7757	20.6668	19.9365
520097	19.6470	20.2354	20.8016	20.2268
520098	20.0289	22.3348	23.4707	21.9054
520100	18.3788	18.3832	19.4788	18.7419
520101	17.8453	19.5186	19.9875	19.1542
520102	19.8354	20.1898	21.0138	20.3351
520103	21.2324	19.4809	20.1092	20.2137
520107	20.5441	20.3747	21.7907	20.8828
520109	18.6322	19.1303	19.7609	19.1753
520110	20.0319	20.4494	21.0055	20.5065
520111	17.2388	17.7834	17.7673	17.6163
520112	18.1827	19.1797	18.9577	18.7858
520113	20.5925	21.1485	21.8852	21.2341
520114	17.3799	16.6616	17.8476	17.2735
520115	17.3755	18.2980	19.2248	18.2555
520116	18.5698	19.8509	20.6922	19.7165
520117	17.4242	18.5414	18.3963	18.1365
520118	12.4422	14.2326	14.8626	13.8369
520120	15.6205	18.7437	*	17.3887
520121	17.5851	19.7305	20.8492	19.5992
520122	16.7552	16.2436	16.9335	16.6326

* Asterisk denotes wage data not available for the provider that year.
** The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average Hourly Wage FY 00	Average Hourly Wage FY 01	Average Hourly Wage FY 02	Average** Hourly Wage (3 yrs)
520123	17.4135	17.3980	17.7986	17.5610
520124	16.3902	17.2619	17.9205	17.1864
520130	15.1639	15.6845	16.6873	15.8395
520131	18.8043	18.7295	20.2591	19.2549
520132	17.2759	15.6379	18.1630	16.9564
520134	17.6094	18.0953	18.8150	18.1846
520135	14.4748	15.8246	17.3476	15.9083
520136	19.9935	19.8480	20.9050	20.2727
520138	20.8922	21.2260	22.5599	21.5577
520139	21.2797	20.9988	21.4042	21.2251
520140	21.4175	21.5207	22.3671	21.7731
520141	16.9543	*	*	16.9543
520142	17.7003	20.5858	21.9432	19.9586
520144	16.6231	18.5701	19.9120	18.4107
520145	17.2356	18.2654	18.7958	18.1015
520146	15.7318	17.9585	18.2370	17.3448
520148	16.9293	17.2421	19.1502	17.8057
520149	13.3032	14.1901	12.8928	13.4360
520151	18.0771	17.3267	18.7070	18.0230
520152	21.3333	19.5858	22.5980	21.0747
520153	15.4467	15.9753	17.0863	16.1441
520154	17.9229	18.5403	19.5994	18.6875
520156	19.8396	21.3377	20.9638	20.7243
520157	17.2784	17.1974	19.6008	18.0185
520159	18.7423	18.6760	17.7649	18.3871
520160	18.8444	19.4173	20.5154	19.5953
520161	18.5742	19.4905	20.1102	19.4069
520170	22.5033	21.5233	21.9857	21.9871
520171	15.7316	17.4560	18.0785	17.1053
520173	20.1410	21.3016	20.9209	20.7812
520177	21.7609	22.7221	24.0139	22.8278
520178	17.0411	18.6936	20.9010	18.7748
520188	*	13.9135	*	13.9135
530002	17.5888	19.3273	21.0560	19.3920
530003	15.7813	16.2139	15.9523	15.9820
530004	16.1862	15.0497	13.3788	14.7758
530005	15.1487	13.3529	15.3255	14.5529
530006	19.3403	18.5894	19.1305	19.0082
530007	18.0601	18.5161	17.7897	18.1450
530008	22.9625	18.8349	19.0113	20.0471
530009	19.4478	22.5009	21.7795	21.2113
530010	18.9317	21.6092	13.9536	17.6719
530011	17.4412	18.7354	19.4606	18.5542
530012	19.4829	18.9923	21.1854	19.8564
530014	17.3158	18.0869	18.4900	17.9675
530015	22.6465	22.4568	23.4040	22.8118
530016	17.7084	18.1562	19.3205	18.4153
530017	13.7131	16.3478	17.7736	15.9421
530018	17.8699	18.3783	19.5986	18.6254
530019	16.7630	18.5430	20.1097	18.3351
530022	17.8781	18.5002	19.6136	18.7082
530023	20.7527	20.1948	20.0677	20.3449
530025	20.3200	21.2598	22.0300	21.1974
530026	18.9175	17.0118	19.8969	18.4992
530027	29.7722	18.1664	25.5067	22.9705
530029	17.7993	16.5092	19.3361	17.7626
530031	13.3775	18.3322	20.1734	17.2600
530032	20.2143	21.0361	20.0132	20.4281

*Asterisk denotes wage data not available for the provider that year.
**The 3-year average hourly wage is weighted by salaries and hours.

TABLE 3A.—FY 2002 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2000, 2001, and 2002]

Urban Area	FY 2002 Average Hourly Wage	3-Year Average Hourly Wage
Abilene, TX	17.7691	17.6806
Aguadilla, PR	10.4485	9.2769
Akron, OH	22.0323	21.5752
Albany, GA	23.7363	22.4591
Albany-Schenectady-Troy, NY	18.9628	18.7015
Albuquerque, NM	21.7519	19.8583
Alexandria, LA	17.9113	17.4211
Allentown-Bethlehem-Easton, PA	22.4824	21.9015
Altoona, PA	20.3592	20.1685
Amarillo, TX	19.4329	18.7074
Anchorage, AK	28.0436	27.7208
Ann Arbor, MI	24.7586	24.5264
Anniston, AL	18.4627	18.1432
Appleton-Oshkosh-Neenah, WI	20.6158	19.7313
Arecibo, PR	10.3287	10.1229
Asheville, NC	20.5253	19.9864
Athens, GA	21.9578	21.2433
Atlanta, GA	22.4386	21.9090
Atlantic-Cape May, NJ	25.1942	24.4875
Auburn-Opelika, AL	18.3605	17.4403
Augusta-Aiken, GA-SC	22.2437	20.3470
Austin-San Marcos, TX	21.4095	20.5134
Bakersfield, CA	21.2373	20.8780
Baltimore, MD	21.9879	21.1182
Bangor, ME	21.4017	20.8620
Barnstable-Yarmouth, MA	30.3987	29.5566
Baton Rouge, LA	18.1796	18.6154
Beaumont-Port Arthur, TX	18.8344	18.7128
Bellingham, WA	26.3828	25.1714
Benton Harbor, MI	19.8256	18.8187
Bergen-Passaic, NJ	26.0785	25.7821
Billings, MT	20.8647	20.9984
Biloxi-Gulfport-Pascagoula, MS	18.8292	17.8351
Binghamton, NY	18.8434	18.7661
Birmingham, AL	19.6498	19.0252
Bismarck, ND	17.8118	16.9730
Bloomington,IN	19.7257	18.9710
Bloomington-Normal, IL	20.1643	19.6505
Boise City, ID	20.1899	19.6753
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	25.1952	24.5070
Boulder-Longmont, CO	21.8607	21.3813
Brazoria, TX	18.3149	18.3834
Bremerton, WA	24.0007	23.7403
Brownsville-Harlingen-San Benito, TX	20.1061	19.5499
Bryan-College Station, TX	20.8102	18.8209
Buffalo-Niagara Falls, NY	21.1015	20.7620
Burlington, VT	22.0478	22.5833
Caguas, PR	10.4833	10.0219
Canton-Massillon, OH	19.9801	19.0700
Casper, WY	21.1855	19.8564
Cedar Rapids, IA	19.4080	19.1733
Champaign-Urbana, IL	20.7605	20.0368
Charleston-North Charleston, SC	20.5383	19.7662
Charleston, WV	20.6672	20.0125
Charlotte-Gastonia-Rock Hill, NC-SC	20.8279	20.4253
Charlottesville, VA	23.5721	23.1481
Chattanooga, TN-GA	20.9025	20.9736
Cheyenne, WY	18.4900	17.9675
Chicago, IL	24.6432	23.9647
Chico-Paradise, CA	21.9881	21.8619
Cincinnati, OH-KY-IN	21.1338	20.5246
Clarksville-Hopkinsville, TN-KY	18.5997	17.8563
Cleveland-Lorain-Elyria, OH	21.0982	20.8296
Colorado Springs, CO	21.7395	20.8047
Columbia, MO	19.3787	19.2453
Columbia, SC	21.1766	20.5897
Columbus, GA-AL	18.8304	18.5114
Columbus, OH	21.3384	21.0849
Corpus Christi, TX	18.6084	18.6824
Corvallis, OR	25.9828	24.7413
Cumberland, MD-WV	18.5294	18.4566
Dallas, TX	22.1658	21.3656
Danville, VA	19.2156	19.0267
Davenport-Moline-Rock Island, IA-IL	19.2716	19.0340
Dayton-Springfield, OH	20.5800	20.3849
Daytona Beach, FL	20.0167	19.7043
Decatur, AL	19.5764	18.8565
Decatur, IL	17.8196	17.7118
Denver, CO	23.0415	22.2645
Des Moines, IA	19.5864	19.3257
Detroit, MI	23.3966	22.7762
Dothan, AL	17.7316	17.1772
Dover, DE	22.9706	21.5842
Dubuque, IA	19.0053	18.6795
Duluth-Superior, MN-WI	22.9429	22.1011
Dutchess County, NY	23.4959	22.7248
Eau Claire, WI	19.8536	19.3107
El Paso, TX	20.5588	19.9419
Elkhart-Goshen, IN	21.5029	20.4359
Elmira, NY	18.7740	18.4812
Enid, OK	18.6448	18.0515
Erie, PA	19.4447	19.3682
Eugene-Springfield, OR	25.5919	23.9337
Evansville, Henderson, IN-KY	18.9936	18.1304
Fargo-Moorhead, ND-MN	20.6740	19.3632
Fayetteville, NC	20.1393	19.0183
Fayetteville-Springdale-Rogers, AR	18.8407	17.4532
Flagstaff, AZ-UT	23.5500	22.9479
Flint, MI	24.3455	24.0039
Florence, AL	17.5023	16.9533
Florence, SC	19.4593	18.9517
Fort Collins-Loveland, CO	22.4100	22.4773
Fort Lauderdale, FL	22.9622	22.1804
Fort Myers-Cape Coral, FL	20.9121	19.9782
Fort Pierce-Port St. Lucie, FL	22.7860	21.5773
Fort Smith, AR-OK	17.9648	17.3902
Fort Walton Beach, FL	20.0841	19.8202
Fort Wayne, IN	20.5313	19.5510
Fort Worth-Arlington, TX	20.9570	20.8452
Fresno, CA	22.2730	22.0075
Gadsden, AL	19.6146	18.7634
Gainesville, FL	21.1521	21.4897
Galveston-Texas City, TX	23.0087	21.6646
Gary, IN	21.2620	20.5771
Glens Falls, NY	18.5967	18.3428
Goldsboro, NC	19.4302	18.4900
Grand Forks, ND-MN	20.2317	19.5346
Grand Junction, CO	21.3486	20.1879
Grand Rapids-Muskegon-Holland, MI	22.4166	22.0645
Great Falls, MT	19.7878	20.7979
Greeley, CO	21.1820	21.0411
Green Bay, WI	20.5432	19.9981
Greensboro-Winston-Salem-High Point, NC	21.2803	20.0780
Greenville, NC	20.7237	20.4264
Greenville-Spartanburg-Anderson, SC	20.5626	19.8772
Hagerstown, MD	18.6617	19.2372
Hamilton-Middletown, OH	20.7196	19.8132
Harrisburg-Lebanon-Carlisle, PA	21.0273	20.8140
Hartford, CT	25.7288	25.0922
Hattiesburg, MS	16.6793	16.3839
Hickory-Morganton-Lenoir, NC	20.8978	19.9473
Honolulu, HI	25.7427	25.2694
Houma, LA	17.7919	17.3205
Houston, TX	21.4873	20.8626
Huntington-Ashland, WV-KY-OH	21.4522	21.2133
Huntsville, AL	19.8172	19.3336
Indianapolis, IN	21.6359	21.2238
Iowa City, IA	21.9959	21.1012
Jackson, MI	20.6529	19.7626
Jackson, MS	18.9422	18.6455
Jackson, TN	20.1078	19.1864
Jacksonville, FL	20.5769	19.8750
Jacksonville, NC	17.0034	16.8680
Jamestown, NY	17.9583	17.1876

TABLE 3A.—FY 2002 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2000, 2001, and 2002]

Urban Area	FY 2002 Average Hourly Wage	3-Year Average Hourly Wage
Janesville-Beloit, WI	21.7281	20.9886
Jersey City, NJ	24.9369	24.8965
Johnson City-Kingsport-Bristol, TN-VA	19.2235	18.6571
Johnstown, PA	19.4611	18.9954
Jonesboro, AR	18.7961	16.9923
Joplin, MO	19.4696	17.8013
Kalamazoo-Battlecreek, MI	23.7355	22.5300
Kankakee, IL	22.0627	20.5487
Kansas City, KS-MO	21.2753	20.5840
Kenosha, WI	21.3454	20.4490
Killeen-Temple, TX	16.2682	19.9750
Knoxville, TN	19.8337	19.1504
Kokomo, IN	20.3602	19.9881
La Crosse, WI-MN	20.6365	19.8718
Lafayette, LA	19.0613	18.3994
Lafayette, IN	20.3481	19.3998
Lake Charles, LA	17.3224	16.7485
Lakeland-Winter Haven, FL	20.2272	19.6704
Lancaster, PA	20.7395	20.1687
Lansing-East Lansing, MI	21.5357	21.4297
Laredo, TX	17.5103	17.6390
Las Cruces, NM	19.2336	18.7690
Las Vegas, NV-AZ	24.9460	24.1211
[1] Lawrence, KS	.....	17.6233
Lawton, OK	19.3702	19.7127
Lewiston-Auburn, ME	20.7185	19.7537
Lexington, KY	19.6123	18.9899
Lima, OH	21.1268	20.0862
Lincoln, NE	22.6963	21.4133
Little Rock-North Little Rock, AR	19.9791	19.2054
Longview-Marshall, TX	19.1225	19.0256
Los Angeles-Long Beach, CA	26.6548	26.0962
Louisville, KY-IN	21.2596	20.4841
Lubbock, TX	18.8491	18.6166
Lynchburg, VA	20.3083	19.4241
Macon, GA	19.9824	19.2057
Madison, WI	23.0613	21.9843
Mansfield, OH	19.4276	18.7455
Mayaguez, PR	10.8433	10.2295
McAllen-Edinburg-Mission, TX	18.6914	18.1962
Medford-Ashland, OR	23.0097	22.6022
Melbourne-Titusville-Palm Bay, FL	22.1149	20.9722
Memphis, TN-AR-MS	20.0303	18.8000
Merced, CA	22.1904	21.6193
Miami, FL	22.1977	21.9246
Middlesex-Somerset-Hunterdon, NJ	25.5879	24.3992
Milwaukee-Waukesha, WI	22.2459	21.4514
Minneapolis-St. Paul, MN-WI	24.3849	23.8437
Missoula, MT	20.8911	20.0992
Mobile, AL	18.0301	17.7727
Modesto, CA	24.1386	22.6578
Monmouth-Ocean, NJ	24.2514	24.2156
Monroe, LA	18.2960	18.0030
Montgomery, AL	16.4170	16.4651
Muncie, IN	22.1725	22.9671
Myrtle Beach, SC	19.5681	18.6951
Naples, FL	21.6388	21.1816
Nashville, TN	21.7612	20.8163
Nassau-Suffolk, NY	30.4363	30.1896
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	27.3029	26.7357
New London-Norwich, CT	25.7135	26.0913
New Orleans, LA	20.1579	19.8724
New York, NY	32.1854	31.5830
Newark, NJ	25.9290	25.4360
Newburgh, NY-PA	24.7917	23.8549
Norfolk-Virginia Beach-Newport News, VA-NC	19.1397	18.4429
Oakland, CA	34.1768	32.8934
Ocala, FL	21.3185	20.6236
Odessa-Midland, TX	22.5425	20.4491
Oklahoma City, OK	19.3952	18.9190
Olympia, WA	25.3219	23.8950
Omaha, NE-IA	21.6670	21.5315
Orange County, CA	24.8160	24.7793
Orlando, FL	21.5114	21.0699
Owensboro, KY	18.5923	17.8512
Panama City, FL	20.2145	19.7652
Parkersburg-Marietta, WV-OH	18.1448	17.9931
Pensacola, FL	18.6539	18.1053
Peoria-Pekin, IL	19.5717	18.6727
Philadelphia, PA-NJ	24.4217	23.9480
Phoenix-Mesa, AZ	21.5030	20.8692
Pine Bluff, AR	17.6144	16.9553
Pittsburgh, PA	21.3283	20.9676
Pittsfield, MA	22.9287	22.3291
Pocatello, ID	21.0779	19.9570
Ponce, PR	11.6402	11.0089
Portland, ME	21.0314	20.7690
Portland-Vancouver, OR-WA	24.7891	23.9331
Providence-Warwick, RI	24.1057	23.4709
Provo-Orem, UT	21.9597	21.5577
Pueblo, CO	19.1954	19.0481
Punta Gorda, FL	20.1130	20.3995
Racine, WI	20.8222	20.1696
Raleigh-Durham-Chapel Hill, NC	21.9030	21.0278
Rapid City, SD	19.7860	18.9541
Reading, PA	21.3801	20.4191
Redding, CA	24.8864	24.7297
Reno, NV	23.2497	22.9230
Richland-Kennewick-Pasco, WA	24.4507	24.4034
Richmond-Petersburg, VA	21.5917	20.8973
Riverside-San Bernardino, CA	24.7903	24.3425
Roanoke, VA	18.6747	18.3527
Rochester, MN	25.5712	24.8162
Rochester, NY	20.8521	20.0838
Rockford, IL	20.5343	19.4475
Rocky Mount, NC	20.3213	19.3679
Sacramento, CA	26.3945	26.1465
Saginaw-Bay City-Midland, MI	21.3941	20.6362
St. Cloud, MN	21.9780	21.3047
[1] St. Joseph, MO	.....	19.3531
St. Louis, MO-IL	19.9244	19.5996
Salem, OR	22.3342	21.8859
Salinas, CA	32.7598	31.8419
Salt Lake City-Ogden, UT	22.0030	21.4144
San Angelo, TX	18.2784	17.4362
San Antonio, TX	19.1516	18.4593
San Diego, CA	25.1307	25.3474
San Francisco, CA	31.5450	30.6851
San Jose, CA	31.6633	30.0720
San Juan-Bayamon, PR	10.6229	10.2284
San Luis Obispo-Atascadero-Paso Robles, CA	24.5182	23.3041
Santa Barbara-Santa Maria-Lompoc, CA	24.0983	23.3594
Santa Cruz-Watsonville, CA	31.1654	30.4145
Santa Fe, NM	22.7435	22.5866
Santa Rosa, CA	29.0793	28.0256
Sarasota-Bradenton, FL	22.5102	21.6154
Savannah, GA	20.6199	20.9278
Scranton-Wilkes Barre-Hazleton, PA	19.3713	18.4721
Seattle-Bellevue-Everett, WA	25.3458	24.3975
Sharon, PA	17.6824	17.4957
Sheboygan, WI	18.7992	18.1442
Sherman-Denison, TX	20.9115	19.8213
Shreveport-Bossier City, LA	20.1898	19.4576
Sioux City, IA-NE	19.5588	18.6963
Sioux Falls, SD	20.3884	19.3356
South Bend, IN	22.2935	21.5894
Spokane, WA	23.7995	23.1813
Springfield, IL	19.3559	18.8869
Springfield, MO	19.1121	18.1563
Springfield, MA	24.2745	23.3313
State College, PA	20.3757	19.7984
Steubenville-Weirton, OH-WV	19.2689	18.6797
Stockton-Lodi, CA	24.1271	23.2304
Sumter, SC	17.3876	17.6174
Syracuse, NY	21.4641	20.7071
Tacoma, WA	25.9158	25.1530
Tallahassee, FL	19.0232	18.5413
Tampa-St. Petersburg-Clearwater, FL	19.9114	19.5352
Terre Haute, IN	19.0337	18.4440
Texarkana, AR-Texarkana, TX	18.5780	17.9809
Toledo, OH	21.8824	21.3504

TABLE 3A.—FY 2002 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2000, 2001, and 2002]

Urban Area	FY 2002 Average Hourly Wage	3-Year Average Hourly Wage
Topeka, KS	19.8816	19.8271
Trenton, NJ	23.2382	22.2118
Tucson, AZ	20.0050	19.2367
Tulsa, OK	19.8607	18.4406
Tuscaloosa, AL	18.2284	17.6510
Tyler, TX	21.5091	20.6026
Utica-Rome, NY	18.5820	18.2679
Vallejo-Fairfield-Napa, CA	30.2552	28.8147
Ventura, CA	24.5276	24.2700
Victoria, TX	18.5790	18.0303
Vineland-Millville-Bridgeton, NJ	23.2940	22.8113
Visalia-Tulare-Porterville, CA	21.4790	21.4191
Waco, TX	18.1355	17.7707
Washington, DC-MD-VA-WV	24.4550	23.7621
Waterloo-Cedar Falls, IA	17.9383	18.0820
Wausau, WI	21.6311	20.7089
West Palm Beach-Boca Raton, FL	21.8130	21.3673
Wheeling, OH-WV	17.8134	16.9419
Wichita, KS	21.4307	20.6976
Wichita Falls, TX	17.5498	16.8374
Williamsport, PA	19.2494	18.4198
Wilmington-Newark, DE-MD	24.2660	24.1627
Wilmington, NC	20.9901	20.6684
Yakima, WA	23.5754	22.3174
Yolo, CA	21.6430	21.4983
York, PA	21.0635	20.3115
Youngstown-Warren, OH	21.3343	21.0926
Yuba City, CA	23.1110	23.0076
Yuma, AZ	20.0535	20.5870

[1] The MSA is empty for FY 2002. The hospital(s) in the MSA received rural status under Section 401 of the Balanced Budget Refinement Act of 1999 (P.L. 106–113). The MSA is assigned the statewide rural wage index (see Table 4B).

TABLE 3B.—FY 2002 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS

[*Based on the sum of the salaries and hours computed for Federal Fiscal years 2000, 2001, and 2002]

Nonurban Area	FY 2002 Average Hourly Wage	3-Year Average Hourly Wage
Alabama	16.3730	16.1146
Alaska	26.4636	26.3425
Arizona	19.3673	18.5370
Arkansas	16.7079	16.0831
California	21.5497	21.3758
Colorado	19.6575	19.2833
Connecticut	26.9422	26.2306

TABLE 3B.—FY 2002 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal years 2000, 2001, and 2002]

Nonurban Area	FY 2002 Average Hourly Wage	3-Year Average Hourly Wage
Delaware	21.3930	20.2349
Florida	19.6192	19.3651
Georgia	18.5057	17.9168
Hawaii	24.7906	23.8356
Idaho	19.4497	18.9015
Illinois	17.9658	17.5928
Indiana	19.4553	18.6527
Iowa	18.1754	17.4857
Kansas	17.4286	16.6018
Kentucky	17.7644	17.3603
Louisiana	16.9467	16.4424
Maine	19.4557	18.9537
Maryland	19.7644	18.9527
Massachusetts	25.5523	24.6681
Michigan	20.0792	19.4470
Minnesota	20.1570	19.2809
Mississippi	16.7955	16.1984
Missouri	17.6049	16.9330
Montana	19.3090	18.6615
Nebraska	18.1647	17.6040
Nevada	21.6995	20.3605
New Hampshire	21.8156	21.4054
New Jersey[1]	.....	.....
New Mexico	19.3566	18.5498
New York	19.0675	18.6183
North Carolina	19.0403	18.3332
North Dakota	17.5784	16.8515
Ohio	19.3379	18.8488
Oklahoma	16.8803	16.1856
Oregon	22.3705	21.7851
Pennsylvania	19.2018	18.6374
Puerto Rico	10.7076	9.6394
Rhode Island[1]	.....	.....
South Carolina	18.9889	18.2492
South Dakota	17.5369	16.6639
Tennessee	17.6873	16.9880
Texas	17.2050	16.4636
Utah	20.1916	19.5942
Vermont	21.1189	20.4055
Virginia	18.3851	17.6464
Washington	22.7769	22.5424
West Virginia	17.9971	17.6684
Wisconsin	20.2251	19.3721
Wyoming	19.5145	19.1625

[1] All counties within the State are classified as urban.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban Area (Constituent Counties)	Wage Index	GAF
0040 Abilene, TX Taylor, TX	0.7983	0.8570
0060 [2] Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4832	0.6077
0080 Akron, OH Portage, OH Summit, OH	0.9876	0.9915

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
0120 Albany, GA Dougherty, GA Lee, GA	1.0640	1.0434
0160 [2] Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8547	0.8981
0200 Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.9750	0.9828
0220 Alexandria, LA Rapides, LA	0.8059	0.8626
0240 Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	1.0077	1.0053
0280 Altoona, PA Blair, PA	0.9126	0.9393
0320 Amarillo, TX Potter, TX Randall, TX	0.8711	0.9098
0380 Anchorage, AK Anchorage, AK	1.2696	1.1776
0440 Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.1098	1.0739
0450 Anniston, AL Calhoun, AL	0.8276	0.8785
0460 Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.9241	0.9474
0470 [2] Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.4832	0.6077
0480 Asheville, NC Buncombe, NC Madison, NC	0.9200	0.9445
0500 Athens, GA Clarke, GA Madison, GA Oconee, GA	0.9842	0.9892
0520 [1] Atlanta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA DeKalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA	1.0058	1.0040

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.1293	1.0868
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8230	0.8751
Lee, AL		
0600 Augusta-Aiken, GA-SC	0.9970	0.9979
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9597	0.9722
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9659	0.9765
Kern, CA		
0720 [1] Baltimore, MD	0.9856	0.9901
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9593	0.9719
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3626	1.2360
Barnstable, MA		
0760 Baton Rouge, LA	0.8149	0.8692
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8442	0.8905
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1826	1.1217
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.9000	0.9304
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1808	1.1205
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9352	0.9552
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8440	0.8903
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 [2] Binghamton, NY	0.8547	0.8981
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8808	0.9168
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7984	0.8571
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8842	0.9192
Monroe, IN		
1040 Bloomington-Normal, IL	0.9038	0.9331
McLean, IL		
1080 Boise City, ID	0.9050	0.9339
Ada, ID		
Canyon, ID		
1123 [1 2] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals)	1.1454	1.0974
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1293	1.0868
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9799	0.9862
Boulder, CO		
1145 Brazoria, TX	0.8209	0.8736
Brazoria, TX		
1150 Bremerton, WA	1.0758	1.0513
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.9012	0.9312
Cameron, TX		
1260 Bryan-College Station, TX	0.9328	0.9535
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9459	0.9626
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9883	0.9920
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 [2] Caguas, PR	0.4832	0.6077
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8956	0.9273
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9496	0.9652
Natrona, WY		
1360 Cedar Rapids, IA	0.8699	0.9090
Linn, IA		
1400 Champaign-Urbana, IL	0.9306	0.9519
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9206	0.9449
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9264	0.9490
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9407	0.9590
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0566	1.0384
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.9369	0.9563
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8747	0.9124
Laramie, WY		
1600 [1] Chicago, IL	1.1046	1.0705
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Will, IL		
1620 Chico-Paradise, CA Butte, CA	0.9856	0.9901
1640 [1] Cincinnati, OH-KY-IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH	0.9473	0.9636
1660 Clarksville-Hopkinsville, TN-KY Christian, KY Montgomery, TN	0.8393	0.8869
1680 [1] Cleveland-Lorain-Elyria, OH Ashtabula, OH Cuyahoga, OH Geauga, OH Lake, OH Lorain, OH Medina, OH	0.9457	0.9625
1720 Colorado Springs, CO El Paso, CO	0.9744	0.9824
1740 Columbia, MO Boone, MO	0.8686	0.9080
1760 Columbia, SC Lexington, SC Richland, SC	0.9492	0.9649
1800 Columbus, GA-AL. Russell, AL Chattahoochee, GA Harris, GA Muscogee, GA	0.8440	0.8903
1840 [1] Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.9565	0.9700
1880 Corpus Christi, TX Nueces, TX San Patricio, TX	0.8341	0.8832
1890 Corvallis, OR Benton, OR	1.1646	1.1100
1900 [2] Cumberland, MD-WV (MD Hospitals) Allegany, MD Mineral, WV	0.8859	0.9204
1900 Cumberland, MD-WV (WV Hospital) Allegany, MD Mineral, WV	0.8306	0.8806
1920 [1] Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	0.9936	0.9956
1950 Danville, VA Danville City, VA Pittsylvania, VA	0.8613	0.9028
1960 Davenport-Moline-Rock Island, IA-IL Scott, IA Henry, IL Rock Island, IL	0.8638	0.9046
2000 Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9225	0.9463
2020 Daytona Beach, FL Flagler, FL Volusia, FL	0.8972	0.9284
2030 Decatur, AL Lawrence, AL Morgan, AL	0.8775	0.9144
2040 [2] Decatur, IL Macon, IL	0.8053	0.8622
2080 [1] Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.0328	1.0223
2120 Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.8779	0.9147
2160 [1] Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0487	1.0331
2180 Dothan, AL Dale, AL Houston, AL	0.7988	0.8574
2190 Dover, DE Kent, DE	1.0296	1.0202
2200 Dubuque, IA Dubuque, IA	0.8519	0.8960
2240 Duluth-Superior, MN-WI St. Louis, MN Douglas, WI	1.0284	1.0194
2281 Dutchess County, NY Dutchess, NY	1.0532	1.0361
2290 [2] Eau Claire, WI Chippewa, WI Eau Claire, WI	0.9068	0.9352
2320 El Paso, TX El Paso, TX	0.9215	0.9456
2330 Elkhart-Goshen, IN Elkhart, IN	0.9638	0.9751
2335 [2] Elmira, NY Chemung, NY	0.8547	0.8981
2340 Enid, OK Garfield, OK	0.8357	0.8843
2360 Erie, PA Erie, PA	0.8716	0.9102
2400 Eugene-Springfield, OR Lane, OR	1.1471	1.0985
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8721	0.9105
2440 Evansville-Henderson, IN-KY (KY Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8514	0.8957
2520 Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.9267	0.9492
2560 Fayetteville, NC Cumberland, NC	0.9027	0.9323
2580 Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.8445	0.8907
2620 Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0556	1.0377
2640 Flint, MI Genesee, MI	1.0913	1.0617
2650 Florence, AL Colbert, AL Lauderdale, AL	0.7889	0.8501
2655 Florence, SC Florence, SC	0.8722	0.9106
2670 Fort Collins-Loveland, CO Larimer, CO	1.0045	1.0031
2680 [1] Ft. Lauderdale, FL Broward, FL	1.0784	1.0530
2700 Fort Myers-Cape Coral, FL Lee, FL	0.9374	0.9567
2710 Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	1.0214	1.0146
2720 Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8053	0.8622
2750 Fort Walton Beach, FL	0.9002	0.9305

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Okaloosa, FL		
2760 Fort Wayne, IN ..	0.9203	0.9447
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Fort Worth-Arlington, TX	0.9394	0.9581
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	0.9984	0.9989
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8792	0.9156
Etowah, AL		
2900 Gainesville, FL ..	0.9481	0.9642
Alachua, FL		
2920 Galveston-Texas City, TX	1.0313	1.0213
Galveston, TX		
2960 Gary, IN	0.9530	0.9676
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8547	0.8981
Warren, NY		
Washington, NY		
2980 Goldsboro, NC ..	0.8709	0.9097
Wayne, NC		
2985 Grand Forks, ND-MN	0.9119	0.9388
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9774	0.9845
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0048	1.0033
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9195	0.9441
Cascade, MT		
3060 Greeley, CO	0.9495	0.9651
Weld, CO		
3080 Green Bay, WI ..	0.9357	0.9555
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9539	0.9682
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC ...	0.9289	0.9507
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9217	0.9457
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 [2] Hagerstown, MD	0.8859	0.9204
Washington, MD		
3200 Hamilton-Middletown, OH	0.9287	0.9506
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9425	0.9603
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1 2] Hartford, CT ..	1.2077	1.1380
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7528	0.8233
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9367	0.9562
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1544	1.1033
Honolulu, HI		
3350 Houma, LA	0.7975	0.8565
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9631	0.9746
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.9616	0.9735
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8883	0.9221
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9698	0.9792
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9859	0.9903
Johnson, IA		
3520 Jackson, MI	0.9257	0.9485
Jackson, MI		
3560 Jackson, MS	0.8491	0.8940
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.9013	0.9313
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9223	0.9461
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8535	0.8972
Onslow, NC		
3610 [2] Jamestown, NY	0.8547	0.8981
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9739	0.9821
Rock, WI		
3640 Jersey City, NJ ..	1.1178	1.0792
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8617	0.9031
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA ..	0.8723	0.9107
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR ..	0.8425	0.8893
Craighead, AR		
3710 Joplin, MO	0.8727	0.9110
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0639	1.0433
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9889	0.9924
Kankakee, IL		
3760 [1] Kansas City, KS-MO	0.9536	0.9680
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9568	0.9702
Kenosha, WI		
3810 [2] Killeen-Temple, TX	0.7714	0.8372

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8890	0.9226
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9184	0.9434
Howard, IN		
Tipton, IN		
3870 La Crosse, WI-MN	0.9250	0.9480
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8544	0.8978
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9121	0.9389
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7765	0.8409
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.9067	0.9351
Polk, FL		
4000 Lancaster, PA	0.9296	0.9512
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9653	0.9761
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.7849	0.8472
Webb, TX		
4100 [2] Las Cruces, NM	0.8676	0.9073
Dona Ana, NM		
4120 [1] Las Vegas, NV-AZ	1.1182	1.0795
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.7812	0.8444
Douglas, KS		
4200 Lawton, OK	0.8682	0.9078
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9287	0.9506
Androscoggin, ME		
4280 Lexington, KY	0.8791	0.9155
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9470	0.9634
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	1.0173	1.0118
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8955	0.9272
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8571	0.8998
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.1961	1.1305
Los Angeles, CA		
4520 [1] Louisville, KY-IN	0.9529	0.9675
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8463	0.8920
Lubbock, TX		
4640 Lynchburg, VA	0.9103	0.9377
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8971	0.9283
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0367	1.0250
Dane, WI		
4800 Mansfield, OH	0.8726	0.9109
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4860	0.6101
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8378	0.8859
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0314	1.0214
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9913	0.9940
Brevard, Fl		
4920 [1] Memphis, TN-AR-MS	0.8978	0.9288
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	0.9947	0.9964
Merced, CA		
5000 [1] Miami, FL	0.9950	0.9966
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1469	1.0984
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9971	0.9980
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN-WI	1.0930	1.0628
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9364	0.9560
Missoula, MT		
5160 Mobile, AL	0.8084	0.8645
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0820	1.0555
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1257	1.0845
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8201	0.8730
Ouachita, LA		
5240 [2] Montgomery, AL	0.7400	0.8137
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9939	0.9958
Delaware, IN		
5330 Myrtle Beach, SC	0.8771	0.9141
Horry, SC		
5345 Naples, FL	0.9699	0.9793
Collier, FL		
5360 [1] Nashville, TN	0.9754	0.9831
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3643	1.2370
Nassau, NY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2294	1.1519
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2077	1.1380
New London, CT		
5560 [1] New Orleans, LA	0.9036	0.9329
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.4427	1.2853
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.1622	1.1084
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1113	1.0749
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8579	0.9004
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5319	1.3392
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9556	0.9694
Marion, FL		
5800 Odessa-Midland, TX	1.0104	1.0071
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8694	0.9086
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1350	1.0906
Thurston, WA		
5920 Omaha, NE-IA	0.9712	0.9802
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1246	1.0837
Orange, CA		
5960 [1] Orlando, FL	0.9642	0.9753
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8334	0.8827
Daviess, KY		
6015 Panama City, FL	0.9061	0.9347
Bay, FL		
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8133	0.8680
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8668	0.9067
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8794	0.9158
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8773	0.9143
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA-NJ	1.0947	1.0639
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9638	0.9751
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7895	0.8506
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9560	0.9697
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1454	1.0974
Berkshire, MA		
6340 Pocatello, ID	0.9448	0.9619
Bannock, ID		
6360 Ponce, PR	0.5218	0.6405
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9427	0.9604
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR-WA	1.1150	1.0774
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0805	1.0545
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9843	0.9892
Utah, UT		
6560 [2] Pueblo, CO	0.8811	0.9170
Pueblo, CO		
6580 Punta Gorda, FL	0.9015	0.9315
Charlotte, FL		
6600 Racine, WI	0.9333	0.9538
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9818	0.9875
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8869	0.9211
Pennington, SD		
6680 Reading, PA	0.9583	0.9713
Berks, PA		
6690 Redding, CA	1.1155	1.0777
Shasta, CA		
6720 Reno, NV	1.0421	1.0286
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.0960	1.0648
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9678	0.9778

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.1112	1.0749
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8371	0.8854
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1462	1.0979
Olmsted, MN		
6840 [1] Rochester, NY	0.9347	0.9548
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9204	0.9448
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9109	0.9381
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1831	1.1220
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9590	0.9717
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9919	0.9944
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.7899	0.8509
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.8931	0.9255
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 [2] Salem, OR	1.0033	1.0023
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4684	1.3009
Monterey, CA		
71601Salt Lake City-Ogden, UT	0.9863	0.9906
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.8193	0.8724
Tom Green, TX		
7240 [1] San Antonio, TX	0.8584	0.9007
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1265	1.0850
San Diego, CA		
7360 [1] San Francisco, CA	1.4140	1.2677
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4193	1.2710
Santa Clara, CA		
7440 [1 2] San Juan-Bayamon, PR	0.4832	0.6077
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0990	1.0668
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0802	1.0543
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3970	1.2573
Santa Cruz, CA		
7490 Santa Fe, NM	1.0194	1.0132
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3034	1.1990
Sonoma, CA		
7510 Sarasota-Bradenton, FL	1.0090	1.0062
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9243	0.9475
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8683	0.9078
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1361	1.0913
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8607	0.9024
Mercer, PA		
7620 [2] Sheboygan, WI	0.9068	0.9352
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9373	0.9566
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9050	0.9339
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.8767	0.9138
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.9139	0.9402
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9993	0.9995
St. Joseph, IN		
7840 Spokane, WA	1.0668	1.0453
Spokane, WA		
7880 Springfield, IL	0.8676	0.9073
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8567	0.8995
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2] Springfield, MA	1.1454	1.0974
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9133	0.9398

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index	GAF
Centre, PA		
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8668	0.9067
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8637	0.9045
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0988	1.0666
San Joaquin, CA		
8140 [2] Sumter, SC	0.8512	0.8955
Sumter, SC		
8160 Syracuse, NY	0.9621	0.9739
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1616	1.1080
Pierce, WA		
8240 [2] Tallahassee, FL	0.8794	0.9158
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.8925	0.9251
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2] Terre Haute, IN	0.8721	0.9105
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana,AR-Texarkana, TX	0.8327	0.8822
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9809	0.9869
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.8912	0.9242
Shawnee, KS		
8480 Trenton, NJ	1.0416	1.0283
Mercer, NJ		
8520 Tucson, AZ	0.8976	0.9287
Pima, AZ		
8560 Tulsa, OK	0.8902	0.9234
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8171	0.8708
Tuscaloosa, AL		
8640 Tyler, TX	0.9641	0.9753
Smith, TX		
8680 [2] Utica-Rome, NY	0.8547	0.8981
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3562	1.2320
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0994	1.0670
Ventura, CA		
8750 Victoria, TX	0.8328	0.8822
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0441	1.0300
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9659	0.9765
Tulare, CA		
8800 Waco, TX	0.8150	0.8693
McLennan, TX		
8840 [1] Washington, DC-MD-VA-WV	1.0962	1.0649
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8677	0.9074
Black Hawk, IA		
8940 Wausau, WI	0.9696	0.9791
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	0.9777	0.9847
Palm Beach, FL		
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8067	0.8632
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8668	0.9067
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9606	0.9728
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7946	0.8543
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8628	0.9039
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.0877	1.0593
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9409	0.9591
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	1.0567	1.0385
Yakima, WA		
9270 Yolo, CA	0.9701	0.9794
Yolo, CA		
9280 York, PA	0.9441	0.9614
York, PA		
9320 Youngstown-Warren, OH	0.9563	0.9699
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0359	1.0244
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.8989	0.9296
Yuma, AZ		

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2002.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban Area	Wage Index	GAF
Alabama	0.7400	0.8137
Alaska	1.1862	1.1240
Arizona	0.8681	0.9077
Arkansas	0.7489	0.8204
California	0.9659	0.9765
Colorado	0.8811	0.9170
Connecticut	1.2077	1.1380
Delaware	0.9589	0.9717
Florida	0.8794	0.9158
Georgia	0.8295	0.8798
Hawaii	1.1112	1.0749
Idaho	0.8718	0.9103
Illinois	0.8053	0.8622
Indiana	0.8721	0.9105
Iowa	0.8147	0.8691
Kansas	0.7812	0.8444
Kentucky	0.7963	0.8556
Louisiana	0.7692	0.8355
Maine	0.8721	0.9105
Maryland	0.8859	0.9204
Massachusetts	1.1454	1.0974
Michigan	0.9000	0.9304

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban Area	Wage Index	GAF
Minnesota	0.9035	0.9329
Mississippi	0.7528	0.8233
Missouri	0.7899	0.8509
Montana	0.8655	0.9058
Nebraska	0.8142	0.8687
Nevada	0.9727	0.9812
New Hampshire	0.9779	0.9848
New Jersey [1]	.....	.....
New Mexico	0.8676	0.9073
New York	0.8547	0.8981
North Carolina	0.8535	0.8972
North Dakota	0.7879	0.8494
Ohio	0.8668	0.9067
Oklahoma	0.7566	0.8261
Oregon	1.0038	1.0026
Pennsylvania	0.8607	0.9024
Puerto Rico	0.4832	0.6077
Rhode Island [1]	.....	.....
South Carolina	0.8512	0.8955
South Dakota	0.7861	0.8481
Tennessee	0.7928	0.8530
Texas	0.7714	0.8372
Utah	0.9051	0.9340
Vermont	0.9608	0.9730
Virginia	0.8241	0.8759
Washington	1.0209	1.0143
West Virginia	0.8067	0.8632
Wisconsin	0.9068	0.9352
Wyoming	0.8747	0.9124

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage Index	GAF
Abilene, TX	0.7983	0.8570
Akron, OH	0.9876	0.9915
Albany, GA	1.0640	1.0434
Albuquerque, NM	0.9750	0.9828
Alexandria, LA	0.8059	0.8626
Allentown-Bethlehem-Easton, PA	1.0077	1.0053
Altoona, PA	0.9126	0.9393
Amarillo, TX	0.8502	0.8948
Anchorage, AK	1.2696	1.1776
Ann Arbor, MI	1.1098	1.0739
Anniston, AL	0.7841	0.8466
Asheville, NC	0.9200	0.9445
Athens, GA	0.9706	0.9798
Atlanta, GA	1.0058	1.0040
Augusta-Aiken, GA-SC	0.9970	0.9979
Austin-San Marcos, TX	0.9597	0.9722
Barnstable-Yarmouth, MA	1.3423	1.2234
Baton Rouge, LA	0.8149	0.8692
Bellingham, WA	1.1296	1.0870
Benton Harbor, MI	0.9000	0.9304
Bergen-Passaic, NJ	1.1808	1.1205
Billings, MT	0.9352	0.9552
Biloxi-Gulfport-Pascagoula, MS	0.8105	0.8660
Binghamton, NY	0.8607	0.9024
Birmingham, AL	0.8808	0.9168
Bismarck, ND	0.7984	0.8571
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1293	1.0868
Burlington, VT (VT Hospitals)	0.9608	0.9730
Burlington, VT (NY Hospitals)	0.9606	0.9728
Caguas, PR	0.4832	0.6077
Casper, WY	0.9346	0.9547
Champaign-Urbana, IL	0.9140	0.9403
Charleston-North Charleston, SC	0.9206	0.9449
Charleston, WV	0.8902	0.9234
Charlotte-Gastonia-Rock Hill, NC-SC	0.9407	0.9590
Chattanooga, TN-GA	0.9181	0.9432
Chicago, IL	1.0917	1.0619
Cincinnati, OH-KY-IN	0.9473	0.9636
Clarksville-Hopkinsville, TN-KY	0.8393	0.8869
Cleveland-Lorain-Elyria, OH	0.9457	0.9625
Columbia, MO	0.8686	0.9080
Columbia, SC	0.9168	0.9422
Columbus, GA-AL	0.8440	0.8903
Columbus, OH	0.9565	0.9700
Corpus Christi, TX	0.8238	0.8757
Dallas, TX	0.9936	0.9956
Davenport-Moline-Rock Island, IA-IL	0.8538	0.8974
Dayton-Springfield, OH	0.9225	0.9463
Denver, CO	1.0328	1.0223
Des Moines, IA	0.8779	0.9147
Dothan, AL	0.7988	0.8574
Dover, DE	1.0003	1.0002
Duluth-Superior, MN-WI	1.0284	1.0194
Eau Claire, WI	0.9068	0.9352
Elkhart-Goshen, IN	0.9517	0.9667
Erie, PA	0.8716	0.9102
Eugene-Springfield, OR	1.1006	1.0678
Fargo-Moorhead, ND-MN	0.9166	0.9421
Fayetteville, NC	0.8869	0.9211
Flagstaff, AZ-UT	1.0105	1.0072
Flint, MI	1.0810	1.0548
Florence, AL	0.7889	0.8501
Florence, SC	0.8722	0.9106
Fort Collins-Loveland, CO	1.0045	1.0031
Ft. Lauderdale, FL	1.0784	1.0530
Fort Pierce-Port St. Lucie, FL	1.0114	1.0078
Fort Smith, AR-OK	0.7857	0.8478
Fort Walton Beach, FL	0.8828	0.9182
Fort Wayne, IN	0.9203	0.9447
Forth Worth-Arlington, TX	0.9394	0.9581
Gadsden, AL	0.8386	0.8864
Gainesville, FL	0.9481	0.9642
Grand Forks, ND-MN	0.9119	0.9388
Grand Junction, CO	0.9774	0.9845
Grand Rapids-Muskegon-Holland, MI	0.9939	0.9958
Great Falls, MT	0.9195	0.9441
Greeley, CO	0.9495	0.9651
Green Bay, WI	0.9357	0.9555
Greensboro-Winston-Salem-High Point, NC	0.9395	0.9582
Greenville, NC	0.9289	0.9507
Greenville-Spartanburg-Anderson, SC	0.9217	0.9457
Harrisburg-Lebanon-Carlisle, PA	0.9425	0.9603
Hartford, CT	1.1571	1.1051
Hattiesburg, MS	0.7528	0.8233
Hickory-Morganton-Lenoir, NC	0.9367	0.9562
Honolulu, HI	1.1544	1.1033
Houston, TX	0.9631	0.9746
Huntington-Ashland, WV-KY-OH	0.9238	0.9472
Huntsville, AL	0.8696	0.9088
Indianapolis, IN	0.9698	0.9792
Iowa City, IA	0.9708	0.9799
Jackson, MS	0.8491	0.8940
Jackson, TN	0.8843	0.9192
Jacksonville, FL	0.9223	0.9461
Johnson City-Kingsport-Bristol, TN-VA	0.8617	0.9031
Jonesboro, AR	0.8115	0.8667
Joplin, MO	0.8528	0.8967
Kalamazoo-Battlecreek, MI	1.0471	1.0320
Kansas City, KS-MO	0.9536	0.9680
Knoxville, TN	0.8890	0.9226
Kokomo, IN	0.9184	0.9434
Lafayette, LA	0.8395	0.8871
Lansing-East Lansing, MI	0.9653	0.9761
Las Vegas, NV-AZ	1.1182	1.0795
Lawton, OK	0.8281	0.8788
Lexington, KY	0.8641	0.9048
Lima, OH	0.9470	0.9634
Lincoln, NE	0.9843	0.9892
Little Rock-North Little Rock, AR	0.8800	0.9162
Longview-Marshall, TX	0.8571	0.8998
Los Angeles-Long Beach, CA	1.1961	1.1305
Louisville, KY-IN	0.9416	0.9596
Lubbock, TX	0.8463	0.8920
Lynchburg, VA	0.8795	0.9158
Macon, GA	0.8971	0.9283
Madison, WI	1.0367	1.0250
Mansfield, OH	0.8726	0.9109
Medford-Ashland, OR	1.0033	1.0023
Memphis, TN-AR-MS	0.8793	0.9157
Miami, FL	0.9950	0.9966
Milwaukee-Waukesha, WI	0.9865	0.9907
Minneapolis-St. Paul, MN-WI	1.0930	1.0628
Missoula, MT	0.9177	0.9429
Mobile, AL	0.8084	0.8645
Modesto, CA	1.0820	1.0555
Monmouth-Ocean, NJ	1.1257	1.0845
Monroe, LA	0.8097	0.8654
Montgomery, AL	0.7400	0.8137
Myrtle Beach, SC	0.8577	0.9002

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage Index	GAF
Nashville, TN	0.9552	0.9691
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2294	1.1519
New London-Norwich, CT	1.1526	1.1021
New Orleans, LA	0.9036	0.9329
New York, NY	1.4287	1.2767
Newark, NJ	1.1622	1.1084
Newburgh, NY-PA	1.0797	1.0539
Oakland, CA	1.5319	1.3392
Odessa-Midland, TX	0.9495	0.9651
Oklahoma City, OK	0.8694	0.9086
Omaha, NE-IA	0.9712	0.9802
Orange County, CA	1.1246	1.0837
Orlando, FL	0.9642	0.9753
Peoria-Pekin, IL	0.8773	0.9143
Philadelphia, PA-NJ	1.0947	1.0639
Pine Bluff, AR	0.7895	0.8506
Pittsburgh, PA	0.9419	0.9598
Pittsfield, MA	0.9904	0.9934
Pocatello, ID	0.9159	0.9416
Portland, ME	0.9427	0.9604
Portland-Vancouver, OR-WA	1.1150	1.0774
Provo-Orem, UT	0.9843	0.9892
Raleigh-Durham-Chapel Hill, NC	0.9818	0.9875
Rapid City, SD	0.8869	0.9211
Reading, PA	0.9216	0.9456
Redding, CA	1.1155	1.0777
Reno, NV	1.0421	1.0286
Richland-Kennewick-Pasco, WA	1.0356	1.0242
Richmond-Petersburg, VA	0.9678	0.9778
Roanoke, VA	0.8371	0.8854
Rochester, MN	1.1462	1.0979
Rockford, IL	0.9042	0.9334
Sacramento, CA	1.1831	1.1220
Saginaw-Bay City-Midland, MI	0.9590	0.9717
St. Cloud, MN	0.9919	0.9944
St. Joseph, MO	0.8121	0.8672
St. Louis, MO-IL	0.8931	0.9255
Salinas, CA	1.4570	1.2940
Salt Lake City-Ogden, UT	0.9863	0.9906
San Diego, CA	1.1265	1.0850
Santa Fe, NM	0.9765	0.9838
Santa Rosa, CA	1.2631	1.1734
Sarasota-Bradenton, FL	1.0090	1.0062
Savannah, GA	0.9243	0.9475
Seattle-Bellevue-Everett, WA	1.1361	1.0913
Sherman-Denison, TX	0.9003	0.9306
Shreveport-Bossier City, LA	0.9050	0.9339
Sioux City, IA-NE	0.8767	0.9138
Sioux Falls, SD	0.8939	0.9261
South Bend, IN	0.9993	0.9995
Spokane, WA	1.0668	1.0453
Springfield, IL	0.8571	0.8998
Springfield, MO	0.8357	0.8843
Stockton-Lodi, CA	1.0988	1.0666
Syracuse, NY	0.9621	0.9739
Tampa-St. Petersburg-Clearwater, FL	0.8925	0.9251
Texarkana,AR-Texarkana, TX	0.8327	0.8822
Toledo, OH	0.9809	0.9869
Topeka, KS	0.8749	0.9125
Tucson, AZ	0.8976	0.9287
Tulsa, OK	0.8760	0.9133
Tuscaloosa, AL	0.8171	0.8708
Tyler, TX	0.9359	0.9556
Victoria, TX	0.8328	0.8822
Waco, TX	0.8150	0.8693
Washington, DC-MD-VA-WV	1.0854	1.0577
Waterloo-Cedar Falls, IA	0.8677	0.9074
Wausau, WI	0.9558	0.9695
West Palm Beach-Boca Raton, FL	0.9777	0.9847
Wichita, KS	0.9237	0.9471
Wichita Falls, TX	0.7946	0.8543
Wilmington-Newark, DE-MD	1.0877	1.0593
Rural Alabama	0.7528	0.8233
Rural Florida	0.8794	0.9158
Rural Illinois (IA Hospitals)	0.8147	0.8691
Rural Illinois (MO Hospitals)	0.8053	0.8622
Rural Kentucky	0.7963	0.8556
Rural Louisiana	0.7692	0.8355
Rural Minnesota	0.9035	0.9329
Rural Missouri	0.7899	0.8509
Rural Montana	0.8655	0.9058
Rural Nebraska	0.8142	0.8687
Rural Nevada	0.9161	0.9418
Rural Oregon	1.0038	1.0026
Rural Texas	0.7714	0.8372
Rural Washington	1.0209	1.0143
Rural Wisconsin	0.9068	0.9352
Rural Wyoming	0.8747	0.9124

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage Index	GAF	Wage Index—Reclass. Hospitals	GAF—Reclass. Hospitals
[1] Aguadilla, PR	1.0025	1.0017	.....	.....
[1] Arecibo, PR	1.0025	1.0017	.....	.....
[1] Caguas, PR	1.0025	1.0017	1.0025	1.0017
Mayaguez, PR	1.0084	1.0057	.....	.....
Ponce, PR	1.0825	1.0558	.....	.....
[1] San Juan-Bayamon, PR	1.0025	1.0017	.....	.....
Rural Puerto Rico	1.0025	1.0017	.....	.....

[1] Hospitals geographically located in the area are assigned the Rural Puerto Rico wage index for FY 2002.

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban Area (Constituent Counties)	Wage Index
0040 Abilene, TX	0.7965
Taylor, TX	
0060 Aguadilla, PR	0.4683
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9876
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0640
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8500
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9750
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8029
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0077
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9126
Blair, PA	
0320 Amarillo, TX –	0.8711
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2570
Anchorage, AK	
0440 Ann Arbor, MI	1.1098
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8276
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9241
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4630
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9200
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9842
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0058
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1293
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8230
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9970
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9597
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9470
Kern, CA	
0720 Baltimore, MD	0.9856
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9593
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3626
Barnstable, MA	
0760 Baton Rouge, LA	0.8149
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8442
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1826
Whatcom, WA	
0870 Benton Harbor, MI	0.8810
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1689
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9352
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8440
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8446
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.8808
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7984
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8842
Monroe, IN	
1040 Bloomington-Normal, IL	0.9038
McLean, IL	
1080 Boise City, ID	0.9050
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1289
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	0.9799
Boulder, CO	
1145 Brazoria, TX	0.8209
Brazoria, TX	
1150 Bremerton, WA	1.0758
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.9012
Cameron, TX	
1260 Bryan-College Station, TX	0.9328
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9459
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9883
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4699
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8956
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9496
Natrona, WY	
1360 Cedar Rapids, IA	0.8699
Linn, IA	
1400 Champaign-Urbana, IL	0.9306
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9206
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9264
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9348
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0566
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9369
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Marion, TN	
1580 Cheyenne, WY	0.8288
Laramie, WY	
1600 Chicago, IL	1.1046
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9856
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9473
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8337
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9457
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9744
El Paso, CO	
1740 Columbia, MO	0.8686
Boone, MO	
1760 Columbia, SC	0.9492
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL–Russell, AL	0.8440
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9565
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8341
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1646
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.8306
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9936
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8613
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8638
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9225
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8982
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8775
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.7987
Macon, IL	
2080 Denver, CO	1.0328
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8779
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0487
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7948
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0296
Kent, DE	
2200 Dubuque, IA	0.8519
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0284
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0532
Dutchess, NY	
2290 Eau Claire, WI	0.8832
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9215
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9638
Elkhart, IN	
2335 Elmira, NY	0.8415
Chemung, NY	
2340 Enid, OK	0.8357
Garfield, OK	
2360 Erie, PA	0.8716
Erie, PA	
2400 Eugene-Springfield, OR	1.1471
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8514
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9267
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.9027
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8445
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0556
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0913
Genesee, MI	
2650 Florence, AL	0.7845
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8722
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0045
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0293
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9374
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0214
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8053
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9002
Okaloosa, FL	
2760 Fort Wayne, IN	0.9203
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9394
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	0.9887
Fresno, CA	
Madera, CA	
2880 Gadsden, AL.	
Etowah, AL	0.8792
2900 Gainesville, FL	0.9481
Alachua, FL	
2920 Galveston-Texas City, TX	1.0313
Galveston, TX	
2960 Gary, IN	0.9530
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8336
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8709

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Wayne, NC	
2985 Grand Forks, ND-MN	0.9069
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9569
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0048
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8870
Cascade, MT	
3060 Greeley, CO	0.9495
Weld, CO	
3080 Green Bay, WI	0.9208
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9539
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9289
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9217
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.8365
Washington, MD	
3200 Hamilton-Middletown, OH	0.9287
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9425
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1533
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7476
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9367
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1539
Honolulu, HI	
3350 Houma, LA	0.7951
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9631
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9616
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8883
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9698
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9859
Johnson, IA	
3520 Jackson, MI	0.9257
Jackson, MI	
3560 Jackson, MS	0.8491
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9013
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9223
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.7622
Onslow, NC	
3610 Jamestown, NY	0.8050
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9739
Rock, WI	
3640 Jersey City, NJ	1.1178
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8617
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8723
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.8425
Craighead, AR	
3710 Joplin, MO	0.8727
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0639
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9889
Kankakee, IL	
3760 Kansas City, KS-MO	0.9536
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9568
Kenosha, WI	
3810 Killeen-Temple, TX	0.7292
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8890
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9126
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9250
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8526
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9121
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7765
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9067
Polk, FL	
4000 Lancaster, PA	0.9296
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9653
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7849
Webb, TX	
4100 Las Cruces, NM	0.8621
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1182
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8656
Douglas, KS	
4200 Lawton, OK	0.8682
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9287
Androscoggin, ME	
4280 Lexington, KY	0.8791
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9470
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0173
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8955
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8571
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1948
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9529
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8449
Lubbock, TX	
4640 Lynchburg, VA	0.9103
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8957
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0337
Dane, WI	
4800 Mansfield, OH	0.8708
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4860
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8378
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0314
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9913
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8978
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9757
Merced, CA	
5000 Miami, FL	0.9950
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1469
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9971
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.0930
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.9364
Missoula, MT	
5160 Mobile, AL	0.8082
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0820
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0872
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8201
Ouachita, LA	
5240 Montgomery, AL	0.7359
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9939
Delaware, IN	
5330 Myrtle Beach, SC	0.8771
Horry, SC	
5345 Naples, FL	0.9699
Collier, FL	
5360 Nashville, TN	0.9754
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3643
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-	1.2238
Danbury, CT	
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.1526
New London, CT	
5560 New Orleans, LA	0.9036
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4427
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1622
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1113
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8579
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5319
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9556
Marion, FL	
5800 Odessa-Midland, TX	1.0104
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8694
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1350
Thurston, WA	
5920 Omaha, NE-IA	0.9712
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1123
Orange, CA	
5960 Orlando, FL	0.9642
Lake, FL	
Orange, FL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8334
Daviess, KY	
6015 Panama City, FL	0.9061
Bay, FL	
6020 Parkersburg-Marietta, WV-OH	0.8133
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8329
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8773
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0947
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9638
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7895
Jefferson, AR	
6280 Pittsburgh, PA	0.9560
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0278
Berkshire, MA	
6340 Pocatello, ID	0.9448
Bannock, ID	
6360 Ponce, PR	0.5218
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9427
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.1111
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0805
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9843
Utah, UT	
6560 Pueblo, CO	0.8604
Pueblo, CO	
6580 Punta Gorda, FL	0.9015
Charlotte, FL	
6600 Racine, WI	0.9333
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8869
Pennington, SD	
6680 Reading, PA	0.9583
Berks, PA	
6690 Redding, CA	1.1155
Shasta, CA	
6720 Reno, NV	1.0440
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0960
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9678
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1111
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8371
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1462
Olmsted, MN	
6840 Rochester, NY	0.9347
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9204
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9109
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1831
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9590
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9851
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9009
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8931
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0011
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4684
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9863
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8193
Tom Green, TX	
7240 San Antonio, TX	0.8584
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1265
San Diego, CA	
7360 San Francisco, CA	1.4140
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4193
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4762
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0990
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0802
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3970
Santa Cruz, CA	
7490 Santa Fe, NM	1.0194
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3034
Sonoma, CA	
7510 Sarasota-Bradenton, FL	1.0090
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9243
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8683
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1361
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.7926
Mercer, PA	
7620 Sheboygan, WI	0.8427
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9373
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9050
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8767
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9139
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9993
St. Joseph, IN	
7840 Spokane, WA	1.0668
Spokane, WA	
7880 Springfield, IL	0.8676
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8567
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0881
Hampden, MA	
Hampshire, MA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
8050 State College, PA	0.9133
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8637
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0815
San Joaquin, CA	
8140 Sumter, SC	0.7794
Sumter, SC	
8160 Syracuse, NY	0.9621
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1616
Pierce, WA	
8240 Tallahassee, FL	0.8527
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.8925
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8532
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8327
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9809
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8912
Shawnee, KS	
8480 Trenton, NJ	1.0416
Mercer, NJ	
8520 Tucson, AZ	0.8967
Pima, AZ	
8560 Tulsa, OK	0.8902
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8171
Tuscaloosa, AL	
8640 Tyler, TX	0.9641
Smith, TX	
8680 Utica-Rome, NY	0.8329
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3562
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0994
Ventura, CA	
8750 Victoria, TX	0.8328
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0441
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9610

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Tulare, CA	
8800 Waco, TX	0.8129
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0962
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8041
Black Hawk, IA	
8940 Wausau, WI	0.9696
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9777
Palm Beach, FL	
9000 Wheeling, WV-OH	0.7985
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9606
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7867
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8521
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0877
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9409
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0567
Yakima, WA	
9270 Yolo, CA	0.9701
Yolo, CA	
9280 York, PA	0.9441
York, PA	
9320 Youngstown-Warren, OH	0.9563
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0359
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8989
Yuma, AZ	

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7339
Alaska	1.1862
Arizona	0.8681
Arkansas	0.7489
California	0.9772
Colorado	0.8811
Connecticut	1.2077
Delaware	0.9589
Florida	0.8812
Georgia	0.8295
Hawaii	1.1112
Idaho	0.8718
Illinois	0.8053
Indiana	0.8721
Iowa	0.8147
Kansas	0.7769
Kentucky	0.7963
Louisiana	0.7601
Maine	0.8721
Maryland	0.8859
Massachusetts	1.1454
Michigan	0.9010
Minnesota	0.9035
Mississippi	0.7528
Missouri	0.7778
Montana	0.8655
Nebraska	0.8142
Nevada	0.9673
New Hampshire	0.9803
New Jersey [1]	.....
New Mexico	0.8676
New York	0.8547
North Carolina	0.8539
North Dakota	0.7879
Ohio	0.8668
Oklahoma	0.7566
Oregon	1.0027
Pennsylvania	0.8617
Puerto Rico	0.4800
Rhode Island [1]	.....
South Carolina	0.8512
South Dakota	0.7861
Tennessee	0.7928
Texas	0.7712
Utah	0.9051
Vermont	0.9466
Virginia	0.8241
Washington	1.0209
West Virginia	0.8067
Wisconsin	0.9079
Wyoming	0.8747

[1] All counties within the State are classified as urban.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.2713	7.6	10.2
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.3874	8.8	11.1
3	01	SURG	*CRANIOTOMY AGE 0-17	1.9594	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.4148	5.5	8.1
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.3628	2.3	3.2
6	01	SURG	CARPAL TUNNEL RELEASE	.7230	2.1	3.0
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6285	8.3	11.1
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.3953	2.0	2.9
9	01	MED	SPINAL DISORDERS & INJURIES	1.3350	5.2	6.9
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2690	5.5	7.2
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8471	3.3	4.3
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9020	4.9	6.3
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.8129	4.5	5.5
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1655	4.8	6.1
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7349	3.0	3.7
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1867	5.1	6.5
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6689	2.7	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9744	4.6	5.8
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6756	3.0	3.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7764	9.0	11.4
21	01	MED	VIRAL MENINGITIS	1.4573	5.5	7.1
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0037	4.0	5.1
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8069	3.4	4.4
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0172	4.0	5.3
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5947	2.7	3.3
26	01	MED	SEIZURE & HEADACHE AGE 0-17	.5981	2.4	3.0
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3514	3.7	5.6
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3609	5.2	6.8
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.6956	3.0	3.8
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3314	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.9165	3.5	4.8
32	01	MED	CONCUSSION AGE >17 W/O CC	.5230	2.0	2.6
33	01	MED	*CONCUSSION AGE 0-17	.2082	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0074	4.2	5.4
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5885	2.7	3.5
36	02	SURG	RETINAL PROCEDURES	.6615	1.2	1.5
37	02	SURG	ORBITAL PROCEDURES	1.1300	2.9	4.3
38	02	SURG	PRIMARY IRIS PROCEDURES	.4751	2.0	2.6
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5986	1.5	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8264	2.4	3.6

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3374	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6302	1.6	2.3
43	02	MED	HYPHEMA	.4578	2.8	3.3
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6554	4.3	5.2
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6760	2.7	3.3
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7962	3.9	5.0
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.5043	2.7	3.4
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0-17	.2972	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7649	3.8	5.1
50	03	SURG	SIALOADENECTOMY	.8158	1.5	1.9
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.7895	1.8	2.7
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7590	1.5	1.9
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.1773	2.3	3.7
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0-17	.4817	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.8483	1.8	2.7
56	03	SURG	RHINOPLASTY	.8787	2.0	2.7
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.2004	2.8	4.3
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	.2735	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8276	1.9	2.8
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2083	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.3541	3.3	5.7
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0-17	.2950	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3718	3.3	4.7
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2319	4.8	6.8
65	03	MED	DYSEQUILIBRIUM	.5326	2.4	2.9
66	03	MED	EPISTAXIS	.5536	2.6	3.3
67	03	MED	EPIGLOTTITIS	.7514	3.0	3.7
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6665	3.6	4.3
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.4948	2.8	3.4
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.4575	2.5	3.0
71	03	MED	LARYNGOTRACHEITIS	.6685	3.1	4.0
72	03	MED	NASAL TRAUMA & DEFORMITY	.6699	2.9	3.7
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7993	3.6	4.7
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3352	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.2096	8.8	10.8
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	3.0129	10.1	12.7
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2416	4.1	5.5
78	04	MED	PULMONARY EMBOLISM	1.3295	6.3	7.2
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.7094	7.6	9.3
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.9215	5.0	6.0
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5177	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.4316	6.0	7.6
83	04	MED	MAJOR CHEST TRAUMA W CC	.9803	4.8	5.9
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5454	2.8	3.5
85	04	MED	PLEURAL EFFUSION W CC	1.2483	5.5	6.9
86	04	MED	PLEURAL EFFUSION W/O CC	.6769	3.0	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.4282	5.5	6.9
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9127	4.5	5.4
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0601	5.3	6.3
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6344	3.7	4.3
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.7937	3.8	4.7
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2296	5.6	6.8
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7443	3.5	4.3
94	04	MED	PNEUMOTHORAX W CC	1.2024	5.4	6.9
95	04	MED	PNEUMOTHORAX W/O CC	.5817	3.2	3.9
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7604	4.1	4.9
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5636	3.2	3.8
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	.7496	3.1	4.6
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6964	2.6	3.3
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5186	1.8	2.2
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8604	3.6	4.7
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5207	2.1	2.7
103	PRE	SURG	HEART TRANSPLANT	20.2413	39.2	58.5

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.8411	13.2	15.3
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.6796	8.8	10.4
106	05	SURG	CORONARY BYPASS W PTCA	7.4396	10.7	12.3
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3125	9.7	10.9
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.5325	9.2	11.2
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9017	7.0	8.0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1576	8.1	10.3
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2865	4.3	5.1
112	05	SURG	NO LONGER VALID	.0000	.0	.0
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.6714	9.8	12.9
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6809	7.3	9.4
115	05	SURG	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GN.	3.3822	7.2	9.2
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.2648	3.6	4.9
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3351	2.8	4.5
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.4339	1.8	2.7
119	05	SURG	VEIN LIGATION & STRIPPING	1.3578	3.3	5.3
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3552	6.7	9.9
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.5787	5.6	6.9
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0241	3.2	3.9
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5883	3.2	5.0
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4072	3.6	4.6
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0406	2.2	2.8
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6836	10.5	13.0
127	05	MED	HEART FAILURE & SHOCK	1.0103	4.5	5.6
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7320	5.2	5.9
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0209	1.7	2.8
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9379	5.0	6.1
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5725	3.8	4.5
132	05	MED	ATHEROSCLEROSIS W CC	.6473	2.5	3.1
133	05	MED	ATHEROSCLEROSIS W/O CC	.5558	1.9	2.3
134	05	MED	HYPERTENSION	.5814	2.7	3.4
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	.9128	3.7	4.8
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5643	2.2	2.8
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.8177	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8222	3.3	4.2
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.4961	2.1	2.5
140	05	MED	ANGINA PECTORIS	.5335	2.2	2.7
141	05	MED	SYNCOPE & COLLAPSE W CC	.7241	3.0	3.8
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5395	2.2	2.7
143	05	MED	CHEST PAIN	.5191	1.7	2.1
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2015	4.3	5.8
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.5899	2.2	2.8
146	06	SURG	RECTAL RESECTION W CC	2.7764	9.6	10.9
147	06	SURG	RECTAL RESECTION W/O CC	1.5993	6.2	6.7
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.5332	11.1	13.1
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5063	6.2	6.7
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.9483	10.5	12.2
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3451	5.3	6.3
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9477	7.4	8.7
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1642	5.1	5.6
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.3519	11.9	14.7
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3273	3.4	4.5
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8421	6.0	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2599	4.4	5.9
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6209	2.0	2.5

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3618	4.2	5.4
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7655	2.2	2.7
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1375	3.2	4.5
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6121	1.6	1.9
163	06	SURG	*HERNIA PROCEDURES AGE 0-17	.6909	2.1	2.1
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3960	7.8	9.0
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2904	4.5	5.0
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4934	4.2	5.4
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8753	2.2	2.6
168	03	SURG	MOUTH PROCEDURES W CC	1.2982	3.6	5.2
169	03	SURG	MOUTH PROCEDURES W/O CC	.6964	1.8	2.3
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	3.0540	9.4	12.5
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1716	3.8	4.8
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3985	5.9	7.6
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6933	3.0	3.9
174	06	MED	G.I. HEMORRHAGE W CC	.9896	4.1	5.1
175	06	MED	G.I. HEMORRHAGE W/O CC	.5419	2.6	3.0
176	06	MED	COMPLICATED PEPTIC ULCER	1.0888	4.4	5.6
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8910	3.9	4.8
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6408	2.7	3.2
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0868	5.1	6.4
180	06	MED	G.I. OBSTRUCTION W CC	.9565	4.6	5.7
181	06	MED	G.I. OBSTRUCTION W/O CC	.5237	3.0	3.5
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7940	3.6	4.6
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5568	2.4	3.0
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.4141	2.5	3.0
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8660	3.6	4.8
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	.3210	2.9	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7868	3.2	4.2
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1250	4.6	6.0
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5776	2.5	3.3
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	1.1897	4.5	7.4
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.6199	12.2	15.5
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8255	6.0	7.1
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.5085	11.6	13.6
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.7294	6.3	7.3
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0863	9.4	10.9
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6111	5.3	6.0
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.5748	8.1	9.6
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2062	4.2	4.7
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.5070	8.4	10.9
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.1811	8.5	12.0
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7986	12.3	15.6
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3291	5.5	7.0
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3627	5.7	7.3
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2047	4.9	6.2
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2207	5.2	6.7
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.7302	3.2	4.1
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1120	4.3	5.5
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6380	2.4	3.0
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	1.9917	4.6	5.1
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.7503	6.1	6.9

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2236	4.6	5.0
212	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	.8457	11.1	11.1
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.9437	7.7	10.0
214	08	SURG	NO LONGER VALID	.0000	.0	.0
215	08	SURG	NO LONGER VALID	.0000	.0	.0
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.3172	8.5	10.9
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	3.2005	11.0	15.2
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.5499	4.7	5.8
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	.9950	2.8	3.3
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17.	.5834	5.3	5.3
221	08	SURG	NO LONGER VALID	.0000	.0	.0
222	08	SURG	NO LONGER VALID	.0000	.0	.0
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.9723	2.1	2.9
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	.7697	1.6	1.9
225	08	SURG	FOOT PROCEDURES	1.1164	3.8	5.3
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5902	5.2	7.3
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7922	2.1	2.7
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.0906	2.7	4.0
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7142	1.9	2.5
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.3598	3.9	5.8
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.4340	3.6	5.4
232	08	SURG	ARTHROSCOPY	.9532	1.8	2.9
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0945	6.3	8.4
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC ..	1.2097	2.7	3.6
235	08	MED	FRACTURES OF FEMUR	.7632	4.1	5.5
236	08	MED	FRACTURES OF HIP & PELVIS	.6889	3.9	4.9
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5325	3.0	3.6
238	08	MED	OSTEOMYELITIS	1.4154	7.4	9.4
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0032	5.4	6.7
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3692	5.6	7.3
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6315	3.3	4.0
242	08	MED	SEPTIC ARTHRITIS	1.0953	5.7	7.2
243	08	MED	MEDICAL BACK PROBLEMS	.7304	4.0	4.9
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7152	4.1	5.1
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4665	2.9	3.6
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5717	3.2	4.1
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5587	2.8	3.6
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.8160	4.1	5.1
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6784	2.7	3.9
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6809	3.5	4.3
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4582	2.4	2.9
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.2533	1.8	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	.7397	4.0	5.0
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	.4294	2.8	3.3
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.2951	2.9	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.8152	4.2	5.4

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.8783	2.2	2.8
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6954	1.7	1.9
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8763	1.8	2.7
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6435	1.3	1.4
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9240	1.7	2.3
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8487	3.0	4.3
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0570	9.1	12.3
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1079	5.6	7.3
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6795	5.2	7.6
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8414	2.4	3.4
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9406	3.3	4.5
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2368	2.5	3.7
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7731	6.9	9.2
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7806	2.5	3.6
271	09	MED	SKIN ULCERS	1.0365	6.2	7.7
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0248	5.2	6.7
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.5638	3.4	4.2
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1927	5.5	7.3
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.6647	3.1	4.6
276	09	MED	NON-MALIGANT BREAST DISORDERS	.7033	4.0	5.0
277	09	MED	CELLULITIS AGE >17 W CC	.8534	5.1	6.1
278	09	MED	CELLULITIS AGE >17 W/O CC	.5487	3.8	4.5
279	09	MED	*CELLULITIS AGE 0-17	.6632	4.2	4.2
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6941	3.5	4.4
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4593	2.5	3.1
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.2565	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	.7152	3.8	4.9
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4204	2.5	3.2
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	2.1297	9.1	11.4
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2343	5.3	6.9
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.9569	8.9	11.7
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1590	4.9	6.0
289	10	SURG	PARATHYROID PROCEDURES	.9573	1.9	3.0
290	10	SURG	THYROID PROCEDURES	.8862	1.7	2.3
291	10	SURG	THYROGLOSSAL PROCEDURES	.5964	1.5	1.8
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.6892	8.8	11.6
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3059	4.3	5.9
294	10	MED	DIABETES AGE >35	.7608	3.8	4.9
295	10	MED	DIABETES AGE 0-35	.7457	3.1	3.9
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8615	4.3	5.5
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC ..	.5047	2.9	3.5
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.4155	2.3	3.0
299	10	MED	INBORN ERRORS OF METABOLISM	.9223	4.4	5.7
300	10	MED	ENDOCRINE DISORDERS W CC	1.1243	5.3	6.6
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6078	3.0	3.8
302	11	SURG	KIDNEY TRANSPLANT	3.3278	7.9	9.3
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.4884	7.5	9.0
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.4618	7.4	9.7
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1502	3.1	3.8
306	11	SURG	PROSTATECTOMY W CC	1.2988	4.3	6.2
307	11	SURG	PROSTATECTOMY W/O CC	.6050	1.9	2.2
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6896	4.8	6.9
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8936	1.8	2.3
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1366	3.3	4.7
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5957	1.5	1.8
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0782	3.3	4.8
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6584	1.8	2.3

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
314	11	SURG	*URETHRAL PROCEDURES, AGE 0-17	.4944	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.1550	4.8	8.3
316	11	MED	RENAL FAILURE	1.3745	5.6	7.3
317	11	MED	ADMIT FOR RENAL DIALYSIS	.6130	2.0	2.9
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1723	5.1	6.6
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5852	2.1	2.8
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8593	4.6	5.6
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5560	3.3	3.9
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.5267	3.6	4.3
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7970	2.5	3.3
324	11	MED	URINARY STONES W/O CC	.4422	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	.6336	3.1	4.0
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4120	2.1	2.7
327	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.3697	2.8	3.2
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7268	2.9	3.9
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4458	1.6	2.0
330	11	MED	*URETHRAL STRICTURE AGE 0-17	.3185	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0640	4.6	6.0
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.6056	2.6	3.4
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.7907	3.9	5.3
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5177	4.3	5.0
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1047	3.1	3.3
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8630	2.8	3.6
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.5861	1.9	2.1
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2191	3.7	5.6
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1555	3.3	5.0
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.2830	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.1306	2.0	3.0
342	12	SURG	CIRCUMCISION AGE >17	.7852	2.5	3.3
343	12	SURG	*CIRCUMCISION AGE 0-17	.1538	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1741	1.6	2.4
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.9149	2.7	4.0
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0304	4.9	6.4
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5660	2.3	3.0
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6998	3.4	4.4
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4128	2.0	2.5
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.7164	3.8	4.6
351	12	MED	*STERILIZATION, MALE	.2360	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6868	3.0	4.2
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8493	5.4	6.8
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5317	5.1	6.1
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9033	3.1	3.3
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7440	2.0	2.3
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.4380	7.5	9.2
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1902	3.7	4.4
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8165	2.6	2.8
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8520	2.4	2.9
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0964	2.1	3.0
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3017	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.8158	2.6	3.6
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.8170	2.9	4.1
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0008	5.8	8.1
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2699	5.6	7.4
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5767	2.4	3.2
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1355	5.6	7.0
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5581	2.5	3.4
370	14	SURG	CESAREAN SECTION W CC	1.0572	4.7	6.1
371	14	SURG	CESAREAN SECTION W/O CC	.6845	3.3	3.7

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5550	2.7	3.3
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3774	2.0	2.3
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6835	2.5	3.1
375	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.5759	2.1	2.3
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.4963	2.5	3.2
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.6892	3.8	5.6
378	14	MED	ECTOPIC PREGNANCY	.8017	2.0	2.4
379	14	MED	THREATENED ABORTION	.4521	2.4	3.6
380	14	MED	ABORTION W/O D&C	.4201	1.6	2.1
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.6628	1.8	2.5
382	14	MED	FALSE LABOR	.1599	1.2	1.3
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.4915	2.8	3.8
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3626	1.6	2.1
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3743	1.8	1.8
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5319	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.0952	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8676	8.6	8.6
389	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.1794	9.3	16.0
390	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1253	3.5	4.3
391	15	MED	*NORMAL NEWBORN	.1524	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.3892	8.3	10.8
393	16	SURG	*SPLENECTOMY AGE 0-17	1.3462	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.8231	5.1	8.1
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8192	3.5	4.7
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	1.0407	3.9	5.0
397	16	MED	COAGULATION DISORDERS	1.2671	4.2	5.6
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.3082	5.1	6.4
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6675	3.0	3.7
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.9346	7.4	10.5
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.9905	9.9	12.8
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1594	3.1	4.4
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8579	6.8	9.1
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8718	3.4	4.6
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9086	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.9939	8.4	11.1
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2426	3.8	4.7
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.2144	6.0	9.2
409	17	MED	RADIOTHERAPY	1.1575	4.9	6.3
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.9991	3.3	4.1
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4481	1.8	2.3
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.5958	1.9	2.4
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3894	6.1	7.8
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.7418	3.5	4.6
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.9067	12.6	16.3
416	18	MED	SEPTICEMIA AGE >17	1.6226	6.4	8.1
417	18	MED	SEPTICEMIA AGE 0-17	.8915	4.4	5.4
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0493	5.3	6.6
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8618	4.0	5.0
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6112	3.0	3.6
421	18	MED	VIRAL ILLNESS AGE >17	.6640	3.2	3.9
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.4757	2.6	3.1
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8365	6.7	9.0
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4518	10.9	15.9
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	.6789	3.2	4.2

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
426	19	MED	DEPRESSIVE NEUROSES	.5261	3.5	4.7
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5348	3.5	5.0
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7242	5.0	7.8
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8367	5.2	6.9
430	19	MED	PSYCHOSES	.7676	6.7	8.9
431	19	MED	CHILDHOOD MENTAL DISORDERS	.6416	5.1	7.1
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7100	3.4	5.1
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2888	2.3	3.2
434	20	MED	NO LONGER VALID	.0000	.0	.0
435	20	MED	NO LONGER VALID	.0000	.0	.0
436	20	MED	NO LONGER VALID	.0000	.0	.0
437	20	MED	NO LONGER VALID	.0000	.0	.0
438	20		NO LONGER VALID	.0000	.0	.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.9332	6.7	9.5
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0806	7.2	10.3
441	21	SURG	HAND PROCEDURES FOR INJURIES	.9295	2.3	3.3
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5304	6.8	9.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9920	2.7	3.6
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7277	3.4	4.4
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4716	2.4	3.0
446	21	MED	*TRAUMATIC INJURY AGE 0-17	.2959	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	.4825	1.8	2.5
448	21	MED	*ALLERGIC REACTIONS AGE 0-17	.0973	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8309	2.8	4.0
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4139	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.2627	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0122	3.8	5.2
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4980	2.2	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8692	3.4	4.9
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4630	1.9	2.6
456	22		NO LONGER VALID	.0000	.0	.0
457	22	MED	NO LONGER VALID	.0000	.0	.0
458	22	SURG	NO LONGER VALID	.0000	.0	.0
459	22	SURG	NO LONGER VALID	.0000	.0	.0
460	22	MED	NO LONGER VALID	.0000	.0	.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1963	2.5	4.6
462	23	MED	REHABILITATION	1.2125	10.4	12.3
463	23	MED	SIGNS & SYMPTOMS W CC	.6800	3.4	4.3
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4628	2.5	3.1
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5445	2.1	3.1
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6416	2.3	3.8
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4585	2.1	3.1
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.8756	11.4	14.7
469			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470			**UNGROUPABLE	.0000	.0	.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.0067	5.0	5.7
472	22	SURG	NO LONGER VALID	.0000	.0	.0
473	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.9324	9.8	15.1
474	04	SURG	NO LONGER VALID	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.9253	10.0	12.7
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2915	10.0	12.3
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.9568	6.7	9.3
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4161	5.9	8.2
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.3900	2.8	3.6
480	PRE	SURG	LIVER TRANSPLANT	10.9812	18.1	23.9
481	PRE	SURG	BONE MARROW TRANSPLANT	8.0438	23.6	25.8
482	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.8583	11.4	14.3
483	PRE	SURG	TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES	15.4629	34.2	41.5
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.2963	11.7	14.9

* Medicare data have been supplemented by data from 19 states for low volume DRGs.
** DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.1724	8.5	10.5
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	5.2888	11.0	14.3
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9585	6.3	8.2
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	5.1965	14.9	19.7
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8948	7.0	9.4
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0584	4.3	5.8
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6353	3.0	3.5
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.8886	13.6	19.0
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8411	4.9	6.3
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	.9754	1.9	2.4
495	PRE	SURG	LUNG TRANSPLANT	8.8252	13.8	16.2
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.7281	8.6	10.5
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.2324	5.8	6.9
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.3026	3.9	4.3
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4507	3.8	5.0
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9385	2.2	2.6
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.7485	9.8	11.9
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5544	5.9	6.9
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2291	3.3	4.2
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	14.1729	28.8	34.7
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	1.4994	2.0	3.4
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.9233	15.7	19.9
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8583	7.3	9.3
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.2967	6.1	8.3
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.7265	3.7	4.9
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3681	5.8	8.0
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.7656	3.6	5.2
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.7813	12.7	14.9
513	PRE	SURG	PANCREAS TRANSPLANT	5.8400	9.7	11.1
514	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH	6.3663	6.7	8.8
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	4.9905	4.2	6.7
516	05	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.7475	4.1	5.0
517	05	SURG	PERC CARDIO PROC W CORONARY ARTERY STENT W/O AMI	2.1379	1.9	2.7
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.6989	2.5	3.7
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.3249	3.8	5.6
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.4195	1.7	2.2
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	.7355	5.0	6.4
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	.6249	8.6	10.4
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	.3997	3.5	4.3

*Medicare data have been supplemented by data from 19 states for low volume DRGs.
**DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
256.31	Premature menopause	N	13	358, 359, 369
256.39	Other ovarian failure	N	13	358, 359, 369
277.7	Dysmetabolic Syndrome X	N	10	299
464.00	Acute laryngitis, without mention of obstruction	N	3 pre	68, 69, 70 482
464.01	Acute laryngitis, with obstruction	N	3 pre	68, 69, 70 482

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis Code	Description	CC	MDC	DRG
464.50	Unspecified supraglottis, without mention of obstruction	N	3	68, 69, 70
			pre	482
464.51	Unspecified supraglottis, with obstruction	N	3	68, 69, 70
			pre	482
521.00	Unspecified dental caries	N	3	185, 186, 187
			pre	482
521.01	Dental caries limited to enamel	N	3	185, 186, 187
			pre	482
521.02	Dental caries extending into dentine	N	3	185, 186, 187
			pre	482
521.03	Dental caries extending into pulp	N	3	185, 186, 187
			pre	482
521.04	Arrested dental caries	N	3	185, 186, 187
			pre	482
521.05	Odontoclasia	N	3	185, 186, 187
			pre	482
521.09	Other dental caries	N	3	185, 186, 187
			pre	482
525.10	Unspecified acquired absence of teeth	N	3	185, 186, 187
			pre	482
525.11	Loss of teeth due to trauma	N	3	185, 186, 187
			pre	482
525.12	Loss of teeth due to periodontal disease	N	3	185, 186, 187
			pre	482
525.13	Loss of teeth due to caries	N	3	185, 186, 187
			pre	482
525.19	Other loss of teeth	N	3	185, 186, 187
			pre	482
530.12	Acute esophagitis	N	6	182, 183, 184
564.00	Unspecified constipation	N	6	182, 183, 184
564.01	Slow transit constipation	N	6	182, 183, 184
564.02	Outlet dysfunction constipation	N	6	182, 183, 184
564.09	Other constipation	N	6	182, 183, 184
602.3	Dysplasia of prostate	N	12	352
608.82	Hematospermia	N	12	352
608.87	Retrograde ejaculation	N	12	352
692.76	Sunburn of second degree	N	9	283, 284
692.77	Sunburn of third degree	N	9	283, 284
718.70	Developmental dislocation of joint, site unspecified	N	8	256
718.71	Developmental dislocation of joint, shoulder region	N	8	256
718.72	Developmental dislocation of joint, upper arm	N	8	256
718.73	Developmental dislocation of joint, forearm	N	8	256
718.74	Developmental dislocation of joint, hand	N	8	256
718.75	Developmental dislocation of joint, pelvic region and thigh	N	8	256
718.76	Developmental dislocation of joint, lower leg	N	8	256
718.77	Developmental dislocation of joint, ankle and foot	N	8	256
718.78	Developmental dislocation of joint, other specified sites	N	8	256
718.79	Developmental dislocation of joint, multiple sites	N	8	256
733.93	Stress fracture of tibia or fibula	Y	8	239
733.94	Stress fracture of the metatarsals	Y	8	239
733.95	Stress fracture of other bone	Y	8	239
772.10	Intraventricular hemorrhage, unspecified grade	Y	15	387, 389
772.11	Intraventricular hemorrhage, Grade I	Y	15	387, 389
772.12	Intraventricular hemorrhage, Grade II	Y	15	387, 389
772.13	Intraventricular hemorrhage, Grade III	Y	15	387, 389
772.14	Intraventricular hemorrhage, Grade IV	Y	15	387, 389
779.7	Perventricular leukomalacia	Y	15	387, 389
793.80	Unspecified abnormal mammogram	N	9	276
793.81	Mammographic microcalcification	N	9	276
793.89	Other abnormal findings on radiological examination breast	N	9	276
840.7	Superior glenoid labrum lesions (SLAP)	N	8	253, 254, 255
			24	487
997.71	Vascular complications of mesenteric artery	Y	6	188, 189, 190
			15	387, 389
997.72	Vascular complications of renal artery	Y	11	331, 332, 333
			15	387, 389
997.79	Vascular complications of other vessels	Y	5	130, 131
			15	387, 389
V10.53	Personal history of malignant neoplasm, renal pelvis	N	17	411, 412
V45.84	Dental restoration status	N	23	467
V49.82	Dental sealant status	N	23	467

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis Code	Description	CC	MDC	DRG
V83.01	Asymptomatic hemophilia A carrier	N	23	467
V83.02	Symptomatic hemophilia A carrier	N	23	467

TABLE 6B.—NEW PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
37.28	Intracardiac echocardiography	N		
44.32	Percutaneous [endoscopic] gastrojejunostomy	Y	6	154–156
			7	201
			10	288
			17	400, 406, 407
67.51	Transabdominal cerclage of cervix	Y	13	360
			14	372, 373
			21	442, 443
			24	486
67.59	Other repair of internal cervical os	Y	13	360
			14	372, 373
			21	442, 443
			24	486
75.38	Fetal pulse oximetry	N		
81.30	Refusion of spine, not otherwise specified	Y	1	4
			8	497, 498
			21	442, 443
			24	486
81.31	Refusion of Atlas-axis spine	Y	1	4
			8	497, 498
			21	442, 443
			24	486
81.32	Refusion of other cervical spine, anterior technique	Y	1	4
			8	496, 519, 520
			21	442, 443
			24	486
81.33	Refusion of other cervical spine, posterior technique	Y	1	4
			8	496, 519, 520
			21	442, 443
			24	486
81.34	Refusion of dorsal and dorsolumbar spine, anterior technique	Y	1	4
			8	496, 497, 498
			21	442, 443
			24	486
81.35	Refusion of dorsal and dorsolumbar spine, posterior technique	Y	1	4
			8	496, 497, 498
			21	442, 443
			24	486
81.36	Refusion of lumbar and lumbosacral spine, anterior technique	Y	1	4
			8	496, 497, 498
			21	442, 443
			24	486
81.37	Refusion of lumbar and lumbosacral spine, lateral transverse process technique.	Y	1	4
			8	496, 497, 498
			21	442, 443
			24	486
81.38	Refusion of lumbar and lumbosacral spine, posterior technique	Y	1	4
			8	496, 497, 498
			21	442, 443
			24	486
81.39	Refusion of spine, not elsewhere classified	Y	1	4
			8	497, 498
			21	442, 443
			24	486
97.44	Nonoperative removal of heart assist system	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
256.3	Other ovarian failure	N	13	358, 359, 369
464.0	Acute laryngitis	N	3	68, 69, 70
			pre	482
521.0	Dental caries	N	3	185, 186, 187
			pre	482
525.1	Loss of teeth due to accident, extraction, or local periodontal disease	N	3	185, 186, 187
			pre	482
564.0	Constipation	N	6	182, 183, 184
772.1	Intraventricular hemorrhage	Y	15	387, 389
793.8	Nonspecific abnormal findings on radiological and other examinations of body structure, breast.	N	9	276

TABLE 6D.—INVALID PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
67.5	Repair of internal cervical os	Y	13	360
			14	372, 373
			21	442, 443
			24	486
81.09	Refusion of spine, any level or technique	Y	1	4
			8	497, 498
			21	442, 443
			24	486

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	DRG
411.81	Acute coronary occlusion without myocardial infarction	Y	5	124, 140
493.00	Extrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
493.10	Intrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
493.20	Chronic obstructive asthma without mention of status asthmaticus or acute exacerbation or unspecified.	Y	4	88
493.90	Asthma, unspecified without mention of status asthmaticus or acute exacerbation or unspecified.	N	4	96, 97, 98
V70.7	Examination of participant in clinical trial	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure Code	Description	OR	MDC	DRG
75.34	Other fetal monitoring	N		

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

CCs that are added to the list are in Table 6F-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principaldiagnosis.

*25631	80600	82010	80637	80606	82021	77212	77210
2580	80601	82011	80638	80607	82022	77213	77211
2581	80602	82012	80639	80608	82030	77214	77212
2588	80603	82013	8064	80609	82031	7797	77213
2589	80604	82019	8065	80610	82032	*7729	77214
*25639	80605	82020	80660	80611	8208	77210	7797
2580	80606	82021	80661	80612	8209	77211	*7769
2581	80607	82022	80662	80613	82100	77212	77210
2588	80608	82030	80669	80614	82101	77213	77211
2589	80609	82031	80670	80615	82110	77214	77212
*6023	80610	82032	80671	80616	82111	7797	77213
5960	80611	8208	80672	80617	*7720	*7760	77214
5996	80612	8209	80679	80618	77210	77210	7797
6010	80613	82100	8068	80619	77211	77211	*7797
6012	80614	82101	8069	80620	77212	77212	7722
6013	80615	82110	8080	80621	77213	77213	7797
6021	80616	82111	8082	80622	77214	77214	*7798
78820	80617	*73394	8083	80623	7797	7797	77210
78829	80618	73310	80843	80624	*77210	*7761	77211
*60887	80619	73311	80849	80625	77210	77210	77212
5970	80620	73312	80851	80626	77211	77211	77213
5994	80621	73313	80852	80627	77212	77212	77214
*73310	80622	73314	80853	80628	77213	77213	7797
73393	80623	73315	80859	80629	77214	77214	*9972
73394	80624	73316	8088	80630	7722	7797	99771
73395	80625	73319	8089	80631	7797	*7762	99772
*73311	80626	73393	82000	80632	*77211	77210	99779
73393	80627	73394	82001	80633	77210	77211	*99771
73394	80628	73395	82002	80634	77211	77212	53640
73395	80629	8058	82003	80635	77212	77213	53641
*73312	80630	8059	82009	80636	77213	77214	53642
73393	80631	80600	82010	80637	77214	7797	53649
73394	80632	80601	82011	80638	7722	*7763	56962
73395	80633	80602	82012	80639	7797	77210	9974
*73313	80634	80603	82013	8064	*77212	77211	99771
73393	80635	80604	82019	8065	77210	77212	99772
73394	80636	80605	82020	80660	77211	77213	99779
73395	80637	80606	82021	80661	77212	77214	*99772
*73314	80638	80607	82022	80662	77213	7797	9975
73393	80639	80608	82030	80669	77214	*7764	99771
73394	8064	80609	82031	80670	7722	77210	99772
73395	8065	80610	82032	80671	7797	77211	99779
*73315	80660	80611	8208	80672	*77213	77212	*99779
73393	80661	80612	8209	80679	77210	77213	9972
73394	80662	80613	82100	8068	77211	77214	99771
73395	80669	80614	82101	8069	77212	7797	99772
*73316	80670	80615	82110	8080	77213	*7765	99779
73393	80671	80616	82111	8082	77214	77210	*99791
73394	80672	80617	*73395	8083	7722	77211	99771
73395	80679	80618	73310	80843	7797	77212	99772
*73319	8068	80619	73311	80849	*77214	77213	99779
73393	8069	80620	73312	80851	77210	77214	*99799
73394	8080	80621	73313	80852	77211	7797	99771
73395	8082	80622	73314	80853	77212	*7766	99772
*73393	8083	80623	73315	80859	77213	77210	99779
73310	80843	80624	73316	8088	77214	77211	*99881
73311	80849	80625	73319	8089	7722	77212	99771
73312	80851	80626	73393	82000	7797	77213	99772
73313	80852	80627	73394	82001	*7722	77214	99779
73314	80853	80628	73395	82002	77210	7797	*99883
73315	80859	80629	8058	82003	77211	*7767	99771
73316	8088	80630	8059	82009	77212	77210	99772
73319	8089	80631	80600	82010	77213	77211	99779
73393	82000	80632	80601	82011	77214	77212	*99889
73394	82001	80633	80602	82012	7797	77213	99771
73395	82002	80634	80603	82013	*7728	77214	99772
8058	82003	80635	80604	82019	77210	7797	99779
8059	82009	80636	80605	82020	77211	*7768	*9989
99771							
99772							
99779							

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

CCs that are deleted from the list are in Table 6G-Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*2563
2580
2581
2588
2589
*7720
7721
*7721
7721
7722
*7722
7721
*7728
7721
*7729
7721
*7760
7721
*7761
7721
*7762
7721
*7763
7721
*7764
7721
*7765
7721
*7766
7721
*7767
7721
*7768
7721
*7769
7721
*7798
7721

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34040	9.0038	2	3	6	12	19
2	6862	9.9787	3	5	8	12	20
3	2	43.5000	35	35	52	52	52
4	6110	7.1570	1	2	5	9	15
5	93853	3.1665	1	1	2	3	7
6	365	2.9671	1	1	2	4	6
7	13063	9.8610	2	4	7	12	20
8	3725	2.8969	1	1	2	4	7
9	1632	6.3192	1	3	5	8	13
10	17754	6.5545	2	3	5	8	13
11	3157	4.0744	1	2	3	5	8
12	47063	5.9088	2	3	4	7	11
13	6504	5.1948	2	3	4	6	9
14	321622	5.8761	2	3	5	7	11
15	146291	3.5528	1	2	3	4	7
16	11235	6.0446	2	3	5	7	12
17	3532	3.3061	1	2	3	4	6
18	26608	5.4190	2	3	4	7	10
19	8346	3.6416	1	2	3	5	7
20	5680	10.1768	3	5	8	13	20
21	1324	6.5249	2	3	5	8	13
22	2560	4.8176	1	2	4	6	9
23	9553	4.1807	1	2	3	5	8
24	53313	4.9825	1	2	4	6	10
25	25528	3.2186	1	2	3	4	6
26	33	2.9091	1	1	2	4	6
27	3519	5.0673	1	1	3	6	11
28	11477	6.2222	1	3	5	8	13
29	4545	3.5982	1	2	3	5	7
30	1	1.0000	1	1	1	1	1
31	3576	4.4855	1	2	3	5	8
32	1770	2.5644	1	1	2	3	5
33	1	1.0000	1	1	1	1	1
34	20753	5.0757	1	2	4	6	10
35	5893	3.3743	1	2	3	4	6
36	3217	1.4719	1	1	1	1	2
37	1465	4.0348	1	1	2	5	9
38	102	2.6569	1	1	2	3	5
39	918	1.9379	1	1	1	2	4
40	1561	3.4209	1	1	2	4	7
42	2235	2.2859	1	1	1	3	5
43	85	3.1882	1	2	3	4	6
44	1244	4.9518	2	3	4	6	9
45	2464	3.1717	1	2	3	4	6
46	3102	4.6518	1	2	4	6	9
47	1284	3.2749	1	1	3	4	6
49	2266	4.8010	1	2	3	6	9
50	2507	1.9418	1	1	1	2	3
51	205	2.6927	1	1	1	2	6
52	224	1.9196	1	1	1	2	3
53	2509	3.5787	1	1	2	4	8
54	2	1.5000	1	1	2	2	2
55	1519	2.7340	1	1	1	3	6
56	517	2.7389	1	1	2	3	5
57	712	4.0478	1	1	2	5	9
59	107	2.7850	1	1	2	3	5
60	2	3.5000	2	2	5	5	5
61	234	5.1624	1	1	2	6	13
62	3	1.3333	1	1	1	2	2
63	2955	4.3993	1	2	3	5	9
64	3070	6.1642	1	2	4	8	13
65	34702	2.8444	1	1	2	4	5
66	7035	3.1599	1	1	2	4	6
67	501	3.5768	1	2	3	4	7
68	16708	4.1241	1	2	3	5	7
69	5417	3.2845	1	2	3	4	6
70	24	2.9167	1	2	2	4	5
71	82	3.8049	1	2	3	4	7
72	893	3.5566	1	2	3	4	6
73	6690	4.3988	1	2	3	6	9

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	39476	9.9112	3	5	7	12	19
76	39399	11.3188	3	5	9	14	21
77	2358	4.9165	1	2	4	7	10
78	32319	6.7837	3	4	6	8	11
79	170615	8.4963	3	4	7	11	16
80	8981	5.6562	2	3	5	7	10
81	4	18.2500	3	3	4	8	58
82	62447	6.9403	2	3	5	9	14
83	6598	5.5518	2	3	4	7	10
84	1539	3.3197	1	2	3	4	6
85	20738	6.3135	2	3	5	8	12
86	2115	3.6648	1	2	3	5	7
87	60486	6.2986	1	3	5	8	12
88	395676	5.1294	2	3	4	6	9
89	529122	5.9478	2	3	5	7	11
90	53985	4.1475	2	3	4	5	7
91	57	4.4561	2	2	3	5	9
92	13873	6.3521	2	3	5	8	12
93	1692	4.0969	1	2	3	5	7
94	12158	6.3088	2	3	5	8	12
95	1621	3.7224	1	2	3	5	7
96	62414	4.6281	2	3	4	6	8
97	31618	3.6509	1	2	3	5	7
98	17	4.3529	1	2	3	4	6
99	19205	3.2061	1	1	2	4	6
100	7656	2.1813	1	1	2	3	4
101	20236	4.3987	1	2	3	5	9
102	5196	2.6522	1	1	2	3	5
103	494	47.2510	9	13	25	61	102
104	37017	11.3083	3	6	9	14	22
105	29991	9.2831	4	5	7	11	17
106	3425	11.4923	5	7	10	14	20
107	88610	10.3724	5	7	9	12	17
108	6099	10.2140	3	5	8	13	19
109	60766	7.6912	4	5	6	9	12
110	53054	9.2130	2	5	7	11	18
111	8563	4.7507	1	2	5	6	8
112	56110	3.6750	1	1	2	5	8
113	42570	12.2362	3	6	9	15	24
114	8788	8.4208	2	4	7	11	16
115	14447	8.1481	1	4	7	11	16
116	333539	3.6045	1	1	2	5	8
117	3750	4.1997	1	1	2	5	9
118	7731	2.6831	1	1	1	3	6
119	1315	4.8783	1	1	3	6	12
120	36315	8.1402	1	2	5	11	18
121	163108	6.3828	2	3	5	8	12
122	79700	3.6981	1	2	3	5	7
123	40952	4.5870	1	1	3	6	11
124	133892	4.3434	1	2	3	5	8
125	80872	2.7656	1	1	2	4	5
126	5210	11.7196	3	6	9	15	22
127	683001	5.2764	2	3	4	7	10
128	9485	5.6128	2	4	5	7	9
129	4174	2.7513	1	1	1	3	6
130	87705	5.6725	2	3	5	7	10
131	27378	4.2134	1	2	4	6	7
132	148681	3.0010	1	1	2	4	6
133	8355	2.3246	1	1	2	3	4
134	36411	3.2406	1	2	3	4	6
135	7338	4.5492	1	2	3	6	9
136	1233	2.7178	1	1	2	3	5
138	195523	3.9935	1	2	3	5	8
139	82943	2.5030	1	1	2	3	5
140	70338	2.6538	1	1	2	3	5
141	91110	3.6692	1	2	3	5	7
142	45981	2.6476	1	1	2	3	5
143	205686	2.1259	1	1	2	3	4
144	82529	5.3248	1	2	4	7	11
145	7242	2.7331	1	1	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
146	10755	10.3134	5	7	9	12	17
147	2637	6.4137	3	5	6	8	9
148	129971	12.2043	5	7	10	15	22
149	18528	6.5116	4	5	6	8	9
150	19921	11.2798	4	7	10	14	20
151	4858	5.8121	2	3	5	8	10
152	4399	8.1444	3	5	7	9	14
153	2100	5.3838	3	4	5	7	8
154	28871	13.1708	4	7	10	16	25
155	6655	4.2026	1	2	3	6	8
156	4	7.5000	1	1	5	6	18
157	7956	5.3910	1	2	4	7	11
158	4670	2.5362	1	1	2	3	5
159	16448	4.9962	1	2	4	6	10
160	11726	2.6594	1	1	2	3	5
161	11205	4.2062	1	1	3	5	9
162	7214	1.9211	1	1	1	2	4
163	7	3.5714	1	1	2	3	4
164	4857	8.4293	4	5	7	10	15
165	2086	4.7895	2	3	5	6	8
166	3559	5.0441	2	2	4	6	10
167	3316	2.6001	1	2	2	3	5
168	1235	4.9247	1	2	3	6	10
169	813	2.3395	1	1	2	3	5
170	11057	11.1942	2	5	8	14	22
171	1274	4.6201	1	2	4	6	9
172	30682	6.9445	2	3	5	9	14
173	2707	3.6679	1	1	3	5	7
174	242054	4.7970	2	3	4	6	9
175	32431	2.9309	1	2	3	4	5
176	15194	5.2285	2	3	4	6	10
177	9272	4.5310	2	2	4	6	8
178	3619	3.0683	1	2	3	4	6
179	12384	5.9738	2	3	5	7	11
180	86181	5.3581	2	3	4	7	10
181	26423	3.4153	1	2	3	4	6
182	234742	4.3758	1	2	3	5	8
183	81065	2.9320	1	1	2	4	5
184	78	2.9487	1	2	2	4	6
185	4769	4.5280	1	2	3	6	9
186	3	9.3333	1	1	9	18	18
187	443	4.0045	1	2	3	5	8
188	76140	5.5645	1	2	4	7	11
189	12060	3.1404	1	1	2	4	6
190	51	6.9608	2	3	4	5	8
191	8964	13.8146	4	6	10	17	27
192	1122	6.5294	2	4	6	8	11
193	5303	12.5218	5	7	10	16	22
194	721	6.7906	2	4	6	8	12
195	4350	10.1616	4	6	9	12	17
196	1166	5.7196	2	4	5	7	10
197	18895	8.9383	3	5	7	11	16
198	5786	4.5380	2	3	4	6	8
199	1725	9.6614	2	4	7	13	21
200	1081	10.3478	1	3	7	13	23
201	1413	13.7594	3	6	11	17	27
202	26168	6.4060	2	3	5	8	13
203	29251	6.6384	2	3	5	9	13
204	57757	5.7995	2	3	4	7	11
205	23128	6.1790	2	3	5	8	12
206	1970	3.8959	1	2	3	5	7
207	31072	5.0836	1	2	4	6	10
208	10149	2.8924	1	1	2	4	6
209	345519	5.0794	3	3	4	6	8
210	121933	6.8207	3	4	6	8	11
211	31780	4.9358	3	4	4	6	7
212	8	10.5000	1	1	4	9	29
213	9241	9.0019	2	4	7	11	18
216	6008	9.6949	2	4	8	12	20
217	16558	13.2636	3	5	9	16	28

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
218	21625	5.4332	2	3	4	7	10
219	19714	3.2188	1	2	3	4	6
220	6	4.0000	1	1	3	7	7
223	13397	2.8551	1	1	2	3	6
224	11274	1.9346	1	1	2	2	3
225	5805	4.8558	1	2	3	6	11
226	5235	6.5958	1	2	4	8	14
227	4703	2.7053	1	1	2	3	5
228	2373	3.7981	1	1	2	5	8
229	1119	2.4781	1	1	2	3	5
230	2401	5.2603	1	2	3	6	11
231	12308	4.9551	1	2	3	6	10
232	811	2.8792	1	1	1	3	7
233	5175	7.5314	2	3	6	10	15
234	3204	3.4263	1	1	3	4	7
235	5095	5.1460	1	2	4	6	9
236	38644	4.8192	1	3	4	6	9
237	1698	3.4953	1	2	3	4	6
238	8028	8.5896	3	4	6	10	16
239	49412	6.2190	2	3	5	8	12
240	11462	6.6902	2	3	5	8	13
241	3138	3.8368	1	2	3	5	7
242	2455	6.6550	2	3	5	8	13
243	88444	4.6699	1	2	4	6	9
244	12282	4.8026	1	2	4	6	9
245	5158	3.4420	1	2	3	4	6
246	1402	3.8759	1	2	3	5	7
247	16979	3.4022	1	1	3	4	7
248	10612	4.8149	1	2	4	6	9
249	11655	3.6913	1	1	2	4	8
250	3495	4.1021	1	2	3	5	7
251	2432	2.8647	1	1	2	4	5
253	19997	4.7768	1	3	4	6	9
254	10514	3.1844	1	2	3	4	6
255	1	3.0000	3	3	3	3	3
256	6110	5.0566	1	2	4	6	10
257	16468	2.7380	1	1	2	3	5
258	16096	1.9335	1	1	2	2	3
259	3805	2.6915	1	1	1	2	6
260	4920	1.4191	1	1	1	2	2
261	1871	2.2720	1	1	1	3	5
262	615	4.0065	1	1	3	5	8
263	23616	11.6630	3	5	8	14	23
264	4081	7.0034	2	3	5	8	14
265	3785	6.7974	1	2	4	8	14
266	2669	3.2345	1	1	2	4	7
267	233	4.2060	1	1	3	6	9
268	910	3.5824	1	1	2	4	7
269	8868	8.2049	2	3	6	10	17
270	2661	3.4540	1	1	2	4	7
271	20588	7.1370	2	4	6	9	13
272	5506	6.1593	2	3	5	8	12
273	1290	4.0233	1	2	3	5	8
274	2357	6.5965	1	3	5	8	13
275	249	4.3373	1	1	3	5	9
276	1183	4.7101	1	2	4	6	8
277	88891	5.7267	2	3	5	7	10
278	30673	4.3084	2	3	4	5	8
279	3	2.3333	1	1	2	4	4
280	15826	4.1974	1	2	3	5	8
281	7203	3.0314	1	1	3	4	6
282	3	1.6667	1	1	2	2	2
283	5701	4.5869	1	2	4	6	9
284	1863	3.0934	1	1	2	4	6
285	6259	10.2903	3	5	8	13	20
286	2081	6.4248	2	3	5	7	13
287	5745	10.5220	3	5	7	12	21
288	2705	5.7360	2	3	4	6	9
289	4801	3.0165	1	1	2	3	7
290	8818	2.3115	1	1	2	2	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
291	66	1.8333	1	1	1	2	3
292	5044	10.2399	2	4	8	13	20
293	385	5.3714	1	2	4	7	11
294	88615	4.6095	1	2	4	6	9
295	3318	3.7372	1	2	3	5	7
296	240055	5.1602	2	2	4	6	10
297	44040	3.4064	1	2	3	4	6
298	95	2.9158	1	1	2	4	5
299	1192	5.3079	1	2	4	7	11
300	16118	6.1471	2	3	5	8	12
301	3221	3.6107	1	2	3	4	7
302	8256	9.0922	4	5	7	10	16
303	19568	8.4192	4	5	7	10	15
304	11902	8.7432	2	4	6	11	18
305	3011	3.6430	1	2	3	5	7
306	7368	5.6221	1	2	3	8	13
307	2096	2.2457	1	1	2	3	4
308	7520	6.2090	1	2	4	8	14
309	4120	2.2998	1	1	2	3	4
310	24033	4.4040	1	1	3	6	10
311	8027	1.8343	1	1	1	2	3
312	1499	4.4957	1	1	3	6	10
313	594	2.3300	1	1	1	3	5
314	1	3.0000	3	3	3	3	3
315	30085	6.9945	1	1	4	9	16
316	105482	6.6227	2	3	5	8	13
317	1536	2.8561	1	1	2	3	6
318	5627	6.0105	1	3	5	8	12
319	428	2.7477	1	1	2	3	6
320	188146	5.3180	2	3	4	6	10
321	30418	3.7849	1	2	3	5	7
322	61	4.1475	2	2	3	5	8
323	17410	3.2221	1	1	2	4	7
324	7562	1.8803	1	1	1	2	3
325	8239	3.8229	1	2	3	5	7
326	2705	2.6699	1	1	2	3	5
327	11	3.0909	1	1	3	4	5
328	668	3.6722	1	1	3	5	8
329	76	2.0000	1	1	1	2	4
331	46575	5.5475	1	3	4	7	11
332	4939	3.2909	1	1	2	4	7
333	290	4.9828	1	2	3	6	10
334	10491	4.8593	2	3	4	6	8
335	11916	3.3087	2	2	3	4	5
336	37713	3.4950	1	2	2	4	7
337	30390	2.1186	1	1	2	3	3
338	1232	5.1080	1	2	3	7	11
339	1628	4.6161	1	1	3	6	11
340	1	1.0000	1	1	1	1	1
341	3766	3.0316	1	1	2	3	6
342	675	3.2207	1	2	2	4	6
344	3519	2.3743	1	1	1	2	5
345	1280	3.7914	1	1	2	4	8
346	4489	5.9082	1	3	4	7	12
347	366	2.9372	1	1	2	4	6
348	3077	4.1677	1	2	3	5	8
349	626	2.5335	1	1	2	3	5
350	6325	4.4024	1	2	4	5	8
352	766	3.9621	1	2	3	5	8
353	2557	6.4490	2	3	5	7	12
354	7609	5.8406	3	3	4	7	11
355	5530	3.2790	2	3	3	4	5
356	25303	2.2920	1	1	2	3	4
357	5580	8.4925	3	4	7	10	16
358	20491	4.3133	2	3	3	5	7
359	30146	2.7284	2	2	3	3	4
360	16032	2.8550	1	2	2	3	5
361	386	2.9948	1	1	2	3	5
363	2875	3.4650	1	2	2	3	7
364	1667	3.8410	1	1	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
365	1737	7.2239	1	3	5	9	16
366	4468	6.7258	1	3	5	8	14
367	584	3.1284	1	1	2	4	6
368	3136	6.4716	2	3	5	8	12
369	3180	3.2500	1	1	2	4	7
370	1151	5.9079	3	3	4	5	10
371	1368	3.6447	2	3	3	4	5
372	964	3.2811	1	2	2	3	5
373	3920	2.2487	1	2	2	3	3
374	130	3.0846	1	2	2	3	4
375	11	2.2727	1	2	2	2	4
376	249	3.0843	1	2	2	4	6
377	51	5.0392	1	1	4	6	12
378	158	2.4177	1	1	2	3	4
379	344	3.4506	1	1	2	4	6
380	60	2.0833	1	1	1	2	5
381	154	2.5065	1	1	1	3	5
382	45	1.2889	1	1	1	1	2
383	1746	3.6174	1	1	2	4	8
384	121	2.1488	1	1	1	2	4
385	1	1.0000	1	1	1	1	1
389	16	13.5000	1	3	6	11	24
390	14	4.0000	1	2	3	6	7
391	1	4.0000	4	4	4	4	4
392	2349	9.6841	3	4	7	12	20
394	1891	7.1364	1	2	4	8	16
395	87679	4.4004	1	2	3	6	9
396	15	4.6667	1	2	4	6	7
397	17705	5.1893	1	2	4	7	10
398	17713	5.9510	2	3	5	7	11
399	1727	3.5634	1	2	3	5	7
400	6492	9.1288	1	3	6	12	20
401	5625	11.2775	2	5	9	15	23
402	1500	4.0933	1	1	3	6	9
403	32010	8.0846	2	3	6	10	17
404	4672	4.2609	1	2	3	6	9
406	2526	9.9224	3	4	7	12	21
407	722	4.4252	1	2	4	5	8
408	2193	8.0228	1	2	5	10	18
409	2831	5.9325	2	3	4	6	12
410	33654	3.9062	1	2	4	5	6
411	13	2.3077	1	1	2	2	5
412	30	2.4000	1	1	2	3	4
413	6478	7.0869	2	3	5	9	14
414	780	4.2885	1	2	3	5	9
415	39078	14.3458	4	6	11	18	28
416	184735	7.3935	2	4	6	9	14
417	18	5.0000	1	2	4	7	9
418	23028	6.1229	2	3	5	7	12
419	15460	4.7254	2	2	4	6	9
420	3116	3.4881	1	2	3	4	6
421	11535	3.7877	1	2	3	5	7
422	83	3.0482	1	2	3	4	6
423	7539	8.1108	2	3	6	10	16
424	1308	13.6338	2	5	9	16	26
425	15852	3.9953	1	2	3	5	8
426	4552	4.4512	1	2	3	5	9
427	1669	4.6207	1	2	3	6	9
428	854	6.9859	1	2	4	8	14
429	26786	6.3438	2	3	5	7	12
430	59892	8.0207	2	3	6	10	16
431	319	6.4326	1	3	5	7	12
432	475	4.7684	1	2	3	5	9
433	5522	3.0996	1	1	2	4	6
434	23062	5.0233	1	2	4	6	9
435	15012	4.1096	1	2	3	5	7
436	3158	12.8322	4	7	11	18	27
437	8588	8.6778	3	5	8	11	15
439	1356	8.3857	1	3	5	10	18
440	5191	9.0326	2	3	6	11	20

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
441	604	3.2235	1	1	2	4	7
442	15588	8.4766	1	3	6	10	18
443	3738	3.4315	1	1	3	4	7
444	5303	4.1495	1	2	3	5	8
445	2450	2.8857	1	1	2	4	5
447	5497	2.4708	1	1	2	3	5
449	28365	3.7491	1	1	3	5	8
450	6935	1.9981	1	1	1	2	4
451	3	1.3333	1	1	1	2	2
452	22930	4.8560	1	2	3	6	10
453	5095	2.7978	1	1	2	3	5
454	4001	4.5431	1	2	3	5	9
455	939	2.5751	1	1	2	3	5
461	3677	4.3723	1	1	2	5	11
462	13083	11.2728	4	6	10	14	21
463	22068	4.1282	1	2	3	5	8
464	6542	3.0011	1	1	2	4	6
465	248	3.0202	1	1	2	4	6
466	1741	3.7030	1	1	2	4	8
467	1137	3.0633	1	1	2	3	6
468	59766	12.9438	3	6	10	17	26
471	11720	5.5506	3	4	4	6	9
473	7663	12.5910	1	3	7	18	32
475	107894	11.2229	2	5	9	15	22
476	4142	10.8841	2	5	9	14	21
477	25336	8.1162	1	3	6	11	17
478	108852	7.3022	1	3	5	9	15
479	24100	3.4573	1	1	3	4	7
480	562	20.9609	7	9	14	25	44
481	383	24.1253	10	18	22	27	39
482	5733	12.9843	4	7	10	15	25
483	42784	39.4479	14	22	33	49	71
484	331	13.0091	2	6	10	17	26
485	2959	9.7080	4	5	7	11	18
486	2017	12.4408	1	5	10	16	25
487	3506	7.3945	1	3	6	10	15
488	784	16.9031	3	7	12	22	36
489	14140	8.4372	2	3	6	10	17
490	5449	5.3577	1	2	4	6	11
491	12291	3.4475	2	2	3	4	6
492	2698	15.6675	3	5	8	25	34
493	55279	5.7576	1	3	5	7	11
494	30109	2.4447	1	1	2	3	5
495	159	15.0503	7	9	12	17	26
496	1475	9.7349	4	5	7	12	19
497	22725	6.1720	2	3	5	7	12
498	21513	3.3043	1	2	3	4	6
499	31077	4.7330	1	2	3	6	9
500	44660	2.6198	1	1	2	3	5
501	2200	10.9600	4	6	8	13	21
502	585	6.5692	3	4	5	8	11
503	5631	4.0012	1	2	3	5	7
504	118	30.5169	9	15	24	41	55
505	145	3.3517	1	1	1	3	7
506	931	17.4071	4	8	14	22	36
507	293	8.3379	2	4	7	11	18
508	671	7.4918	2	3	5	9	15
509	177	4.5367	1	2	4	6	9
510	1650	7.2358	2	3	5	9	15
511	608	4.8158	1	2	3	6	11
	11079177						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34040	9.0038	2	3	6	12	19
2	6862	9.9787	3	5	8	12	20
3	2	43.5000	35	35	52	52	52
4	6120	7.1526	1	2	5	9	15
5	93853	3.1665	1	1	2	3	7
6	365	2.9671	1	1	2	4	6
7	13283	9.8362	2	4	7	12	20
8	3821	2.9089	1	1	2	4	7
9	1631	6.3194	1	3	5	8	13
10	17754	6.5545	2	3	5	8	13
11	3157	4.0744	1	2	3	5	8
12	47063	5.9088	2	3	4	7	11
13	6504	5.1948	2	3	4	6	9
14	321622	5.8761	2	3	5	7	11
15	146291	3.5528	1	2	3	4	7
16	11235	6.0446	2	3	5	7	12
17	3532	3.3061	1	2	3	4	6
18	26608	5.4190	2	3	4	7	10
19	8346	3.6416	1	2	3	5	7
20	5680	10.1768	3	5	8	13	20
21	1324	6.5249	2	3	5	8	13
22	2560	4.8176	1	2	4	6	9
23	9553	4.1807	1	2	3	5	8
24	53313	4.9825	1	2	4	6	10
25	25528	3.2186	1	2	3	4	6
26	33	2.9091	1	1	2	4	6
27	3519	5.0673	1	1	3	6	11
28	11477	6.2222	1	3	5	8	13
29	4545	3.5982	1	2	3	5	7
30	1	1.0000	1	1	1	1	1
31	3576	4.4855	1	2	3	5	8
32	1770	2.5644	1	1	2	3	5
33	1	1.0000	1	1	1	1	1
34	20751	5.0759	1	2	4	6	10
35	5893	3.3743	1	2	3	4	6
36	3217	1.4719	1	1	1	1	2
37	1465	4.0348	1	1	2	5	9
38	102	2.6569	1	1	2	3	5
39	918	1.9379	1	1	1	2	4
40	1561	3.4209	1	1	2	4	7
42	2235	2.2859	1	1	1	3	5
43	85	3.1882	1	2	3	4	6
44	1244	4.9518	2	3	4	6	9
45	2464	3.1717	1	2	3	4	6
46	3102	4.6518	1	2	4	6	9
47	1284	3.2749	1	1	3	4	6
49	2266	4.8010	1	2	3	6	9
50	2507	1.9418	1	1	1	2	3
51	205	2.6927	1	1	1	2	6
52	224	1.9196	1	1	1	2	3
53	2512	3.5760	1	1	2	4	8
54	2	1.5000	1	1	2	2	2
55	1521	2.7331	1	1	1	3	6
56	517	2.7389	1	1	2	3	5
57	712	4.0478	1	1	2	5	9
59	107	2.7850	1	1	2	3	5
60	2	3.5000	2	2	5	5	5
61	234	5.1624	1	1	2	6	13
62	3	1.3333	1	1	1	2	2
63	3039	4.4399	1	2	3	5	9
64	3070	6.1642	1	2	4	8	13
65	34702	2.8444	1	1	2	4	5
66	7035	3.1599	1	1	2	4	6
67	501	3.5768	1	2	3	4	7
68	16804	4.1202	1	2	3	5	7
69	5465	3.2767	1	2	3	4	6
70	24	2.9167	1	2	2	4	5
71	82	3.8049	1	2	3	4	7
72	893	3.5566	1	2	3	4	6
73	6690	4.3988	1	2	3	6	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	39476	9.9112	3	5	7	12	19
76	40377	11.4074	3	5	9	14	22
77	2406	5.0000	1	2	4	7	10
78	32319	6.7837	3	4	6	8	11
79	170615	8.4963	3	4	7	11	16
80	8981	5.6562	2	3	5	7	10
81	4	18.2500	3	3	4	8	58
82	62447	6.9403	2	3	5	9	14
83	6598	5.5518	2	3	4	7	10
84	1539	3.3197	1	2	3	4	6
85	20738	6.3135	2	3	5	8	12
86	2115	3.6648	1	2	3	5	7
87	60486	6.2986	1	3	5	8	12
88	395676	5.1294	2	3	4	6	9
89	529122	5.9478	2	3	5	7	11
90	53985	4.1475	2	3	4	5	7
91	57	4.4561	2	2	3	5	9
92	13873	6.3521	2	3	5	8	12
93	1692	4.0969	1	2	3	5	7
94	12158	6.3088	2	3	5	8	12
95	1621	3.7224	1	2	3	5	7
96	62414	4.6281	2	3	4	6	8
97	31618	3.6509	1	2	3	5	7
98	17	4.3529	1	2	3	4	6
99	19205	3.2061	1	1	2	4	6
100	7656	2.1813	1	1	2	3	4
101	20236	4.3987	1	2	3	5	9
102	5196	2.6522	1	1	2	3	5
103	494	47.2510	9	13	25	61	102
104	19992	14.2362	6	8	12	17	25
105	26203	9.7712	4	6	8	11	17
106	3425	11.4923	5	7	10	14	20
107	88610	10.3724	5	7	9	12	17
108	6099	10.2140	3	5	8	13	19
109	60766	7.6912	4	5	6	9	12
110	53054	9.2130	2	5	7	11	18
111	8563	4.7507	1	2	5	6	8
113	42570	12.2362	3	6	9	15	24
114	8788	8.4208	2	4	7	11	16
115	14447	8.1481	1	4	7	11	16
116	101326	4.5123	1	2	3	6	9
117	3750	4.1997	1	1	2	5	9
118	7731	2.6831	1	1	1	3	6
119	1315	4.8783	1	1	3	6	12
120	37900	8.5509	1	2	6	11	19
121	163108	6.3828	2	3	5	8	12
122	79700	3.6981	1	2	3	5	7
123	40952	4.5870	1	1	3	6	11
124	133892	4.3434	1	2	3	5	8
125	80872	2.7656	1	1	2	4	5
126	5210	11.7196	3	6	9	15	22
127	683001	5.2764	2	3	4	7	10
128	9485	5.6128	2	4	5	7	9
129	4174	2.7513	1	1	1	3	6
130	87705	5.6725	2	3	5	7	10
131	27378	4.2134	1	2	4	6	7
132	148681	3.0010	1	1	2	4	6
133	8355	2.3246	1	1	2	3	4
134	36411	3.2406	1	2	3	4	6
135	7338	4.5492	1	2	3	6	9
136	1233	2.7178	1	1	2	3	5
138	195523	3.9935	1	2	3	5	8
139	82943	2.5030	1	1	2	3	5
140	70338	2.6538	1	1	2	3	5
141	91110	3.6692	1	2	3	5	7
142	45981	2.6476	1	1	2	3	5
143	205686	2.1259	1	1	2	3	4
144	82529	5.3248	1	2	4	7	11
145	7242	2.7331	1	1	2	3	5
146	10755	10.3134	5	7	9	12	17

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
147	2637	6.4137	3	5	6	8	9
148	130066	12.2031	5	7	10	15	22
149	18560	6.5100	4	5	6	8	9
150	19923	11.2795	4	7	10	14	20
151	4860	5.8123	2	3	5	8	10
152	4399	8.1444	3	5	7	9	14
153	2100	5.3838	3	4	5	7	8
154	28872	13.1709	4	7	10	16	25
155	6655	4.2026	1	2	3	6	8
156	4	7.5000	1	1	5	6	18
157	7963	5.3929	1	2	4	7	11
158	4671	2.5359	1	1	2	3	5
159	16456	4.9981	1	2	4	6	10
160	11727	2.6592	1	1	2	3	5
161	11208	4.2057	1	1	3	5	9
162	7217	1.9216	1	1	1	2	4
163	7	3.5714	1	1	2	3	4
164	4857	8.4293	4	5	7	10	15
165	2086	4.7895	2	3	5	6	8
166	3559	5.0441	2	2	4	6	10
167	3316	2.6001	1	2	2	3	5
168	1361	4.7649	1	2	3	6	10
169	843	2.3238	1	1	2	3	5
170	12291	10.9867	2	4	8	14	22
171	1408	4.5014	1	2	4	6	9
172	30682	6.9445	2	3	5	9	14
173	2707	3.6679	1	1	3	5	7
174	242053	4.7969	2	3	4	6	9
175	32431	2.9309	1	2	3	4	5
176	15194	5.2285	2	3	4	6	10
177	9272	4.5310	2	2	4	6	8
178	3619	3.0683	1	2	3	4	6
179	12384	5.9738	2	3	5	7	11
180	86181	5.3581	2	3	4	7	10
181	26423	3.4153	1	2	3	4	6
182	245515	4.3381	1	2	3	5	8
183	84480	2.9129	1	1	2	4	5
184	80	2.9500	1	2	2	4	6
185	4826	4.5089	1	2	3	6	9
186	3	9.3333	1	1	9	18	18
187	683	3.9253	1	1	3	5	8
188	76140	5.5645	1	2	4	7	11
189	12060	3.1404	1	1	2	4	6
190	51	6.9608	2	3	4	5	8
191	8941	13.8186	4	6	10	17	27
192	1122	6.5294	2	4	6	8	11
193	5303	12.5218	5	7	10	16	22
194	721	6.7906	2	4	6	8	12
195	4350	10.1616	4	6	9	12	17
196	1166	5.7196	2	4	5	7	10
197	18895	8.9383	3	5	7	11	16
198	5786	4.5380	2	3	4	6	8
199	1725	9.6614	2	4	7	13	21
200	1081	10.3478	1	3	7	13	23
201	1431	13.7393	3	6	11	17	27
202	26168	6.4060	2	3	5	8	13
203	29251	6.6384	2	3	5	9	13
204	57757	5.7995	2	3	4	7	11
205	23128	6.1790	2	3	5	8	12
206	1970	3.8959	1	2	3	5	7
207	31072	5.0836	1	2	4	6	10
208	10149	2.8924	1	1	2	4	6
209	345519	5.0794	3	3	4	6	8
210	121933	6.8207	3	4	6	8	11
211	31780	4.9358	3	4	4	6	7
212	8	10.5000	1	1	4	9	29
213	9241	9.0019	2	4	7	11	18
216	6008	9.6949	2	4	8	12	20
217	16558	13.2636	3	5	9	16	28
218	21621	5.4328	2	3	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	19714	3.2188	1	2	3	4	6
220	6	4.0000	1	1	3	7	7
223	13397	2.8551	1	1	2	3	6
224	11274	1.9346	1	1	2	2	3
225	5805	4.8558	1	2	3	6	11
226	5230	6.5887	1	2	4	8	14
227	4702	2.7052	1	1	2	3	5
228	2373	3.7981	1	1	2	5	8
229	1118	2.4785	1	1	2	3	5
230	2395	5.2551	1	2	3	6	11
231	11467	4.9383	1	2	3	6	11
232	811	2.8792	1	1	1	3	7
233	5159	7.5251	1	3	6	10	15
234	3186	3.4203	1	1	3	4	7
235	5095	5.1460	1	2	4	6	9
236	38644	4.8192	1	3	4	6	9
237	1698	3.4953	1	2	3	4	6
238	8028	8.5896	3	4	6	10	16
239	49410	6.2190	2	3	5	8	12
240	11462	6.6902	2	3	5	8	13
241	3138	3.8368	1	2	3	5	7
242	2455	6.6550	2	3	5	8	13
243	88325	4.6695	1	2	4	6	9
244	12281	4.8027	1	2	4	6	9
245	5158	3.4420	1	2	3	4	6
246	1402	3.8759	1	2	3	5	7
247	16979	3.4022	1	1	3	4	7
248	10612	4.8149	1	2	4	6	9
249	11431	3.6726	1	1	2	4	8
250	3495	4.1021	1	2	3	5	7
251	2432	2.8647	1	1	2	4	5
253	19997	4.7768	1	3	4	6	9
254	10514	3.1844	1	2	3	4	6
255	1	3.0000	3	3	3	3	3
256	6097	5.0576	1	2	4	6	10
257	16468	2.7380	1	1	2	3	5
258	16096	1.9335	1	1	2	2	3
259	3805	2.6915	1	1	1	2	6
260	4920	1.4191	1	1	1	2	2
261	1875	2.2704	1	1	1	3	5
262	622	3.9807	1	1	3	5	8
263	23616	11.6630	3	5	8	14	23
264	4081	7.0034	2	3	5	8	14
265	3785	6.7974	1	2	4	8	14
266	2669	3.2345	1	1	2	4	7
267	233	4.2060	1	1	3	6	9
268	910	3.5824	1	1	2	4	7
269	8868	8.2049	2	3	6	10	17
270	2662	3.4530	1	1	2	4	7
271	20588	7.1370	2	4	6	9	13
272	5506	6.1593	2	3	5	8	12
273	1290	4.0233	1	2	3	5	8
274	2357	6.5965	1	3	5	8	13
275	249	4.3373	1	1	3	5	9
276	1189	4.7258	1	2	4	6	8
277	88891	5.7267	2	3	5	7	10
278	30673	4.3084	2	3	4	5	8
279	3	2.3333	1	1	2	4	4
280	15826	4.1974	1	2	3	5	8
281	7203	3.0314	1	1	3	4	6
282	3	1.6667	1	1	2	2	2
283	5701	4.5869	1	2	4	6	9
284	1863	3.0934	1	1	2	4	6
285	6259	10.2903	3	5	8	13	20
286	2081	6.4248	2	3	5	7	13
287	5745	10.5220	3	5	7	12	21
288	2705	5.7360	2	3	4	6	9
289	4801	3.0165	1	1	2	3	7
290	8818	2.3115	1	1	2	2	4
291	66	1.8333	1	1	1	2	3

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
292	4994	10.2367	2	4	8	13	20
293	385	5.3714	1	2	4	7	11
294	88615	4.6095	1	2	4	6	9
295	3318	3.7372	1	2	3	5	7
296	240050	5.1602	2	2	4	6	10
297	44040	3.4064	1	2	3	4	6
298	95	2.9158	1	1	2	4	5
299	1192	5.3079	1	2	4	7	11
300	16118	6.1471	2	3	5	8	12
301	3221	3.6107	1	2	3	4	7
302	7924	8.8892	4	5	7	10	15
303	19568	8.4192	4	5	7	10	15
304	11900	8.7432	2	4	6	11	18
305	3011	3.6430	1	2	3	5	7
306	7368	5.6221	1	2	3	8	13
307	2096	2.2457	1	1	2	3	4
308	7520	6.2090	1	2	4	8	14
309	4120	2.2998	1	1	2	3	4
310	24033	4.4040	1	1	3	6	10
311	8027	1.8343	1	1	1	2	3
312	1499	4.4957	1	1	3	6	10
313	594	2.3300	1	1	1	3	5
314	1	3.0000	3	3	3	3	3
315	30492	7.1080	1	1	4	9	16
316	105482	6.6227	2	3	5	8	13
317	1536	2.8561	1	1	2	3	6
318	5627	6.0105	1	3	5	8	12
319	428	2.7477	1	1	2	3	6
320	188146	5.3180	2	3	4	6	10
321	30418	3.7849	1	2	3	5	7
322	61	4.1475	2	2	3	5	8
323	17410	3.2221	1	1	2	4	7
324	7562	1.8803	1	1	1	2	3
325	8239	3.8229	1	2	3	5	7
326	2705	2.6699	1	1	2	3	5
327	11	3.0909	1	1	3	4	5
328	668	3.6722	1	1	3	5	8
329	76	2.0000	1	1	1	2	4
331	46575	5.5475	1	3	4	7	11
332	4939	3.2909	1	1	2	4	7
333	290	4.9828	1	2	3	6	10
334	10491	4.8593	2	3	4	6	8
335	11916	3.3087	2	2	3	4	5
336	37713	3.4950	1	2	2	4	7
337	30390	2.1186	1	1	2	3	3
338	1232	5.1080	1	2	3	7	11
339	1628	4.6161	1	1	3	6	11
340	1	1.0000	1	1	1	1	1
341	3766	3.0316	1	1	2	3	6
342	675	3.2207	1	2	2	4	6
344	3519	2.3743	1	1	1	2	5
345	1280	3.7914	1	1	2	4	8
346	4489	5.9082	1	3	4	7	12
347	366	2.9372	1	1	2	4	6
348	3077	4.1677	1	2	3	5	8
349	626	2.5335	1	1	2	3	5
350	6325	4.4024	1	2	4	5	8
352	766	3.9621	1	2	3	5	8
353	2557	6.4490	2	3	5	7	12
354	7609	5.8406	3	3	4	7	11
355	5530	3.2790	2	3	3	4	5
356	25303	2.2920	1	1	2	3	4
357	5580	8.4925	3	4	7	10	16
358	20492	4.3132	2	3	3	5	7
359	30149	2.7284	2	2	3	3	4
360	16035	2.8549	1	2	2	3	5
361	386	2.9948	1	1	2	3	5
363	2875	3.4650	1	2	2	3	7
364	1666	3.8427	1	1	3	5	8
365	1737	7.2239	1	3	5	9	16

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
366	4468	6.7258	1	3	5	8	14
367	584	3.1284	1	1	2	4	6
368	3136	6.4716	2	3	5	8	12
369	3178	3.2498	1	1	2	4	7
370	1151	5.9079	3	3	4	5	10
371	1368	3.6447	2	3	3	4	5
372	964	3.2811	1	2	2	3	5
373	3920	2.2487	1	2	2	3	3
374	130	3.0846	1	2	2	3	4
375	11	2.2727	1	2	2	2	4
376	249	3.0843	1	2	2	4	6
377	51	5.0392	1	1	4	6	12
378	158	2.4177	1	1	2	3	4
379	344	3.4506	1	1	2	4	6
380	60	2.0833	1	1	1	2	5
381	154	2.5065	1	1	1	3	5
382	45	1.2889	1	1	1	1	2
383	1746	3.6174	1	1	2	4	8
384	121	2.1488	1	1	1	2	4
385	1	1.0000	1	1	1	1	1
389	16	13.5000	1	3	6	11	24
390	14	4.0000	1	2	3	6	7
391	1	4.0000	4	4	4	4	4
392	2349	9.6841	3	4	7	12	20
394	1891	7.1364	1	2	4	8	16
395	87678	4.4004	1	2	3	6	9
396	15	4.6667	1	2	4	6	7
397	17705	5.1893	1	2	4	7	10
398	17713	5.9510	2	3	5	7	11
399	1727	3.5634	1	2	3	5	7
400	6490	9.1307	1	3	6	12	20
401	5622	11.2782	2	5	9	15	23
402	1500	4.0933	1	1	3	6	9
403	31997	8.0849	2	3	6	10	17
404	4670	4.2621	1	2	3	6	9
406	2527	9.9201	3	4	7	12	21
407	723	4.4219	1	2	4	5	8
408	2196	8.0255	1	2	5	10	18
409	2831	5.9325	2	3	4	6	12
410	33654	3.9062	1	2	4	5	6
411	13	2.3077	1	1	2	2	5
412	30	2.4000	1	1	2	3	4
413	6491	7.0875	2	3	5	9	14
414	782	4.2813	1	2	3	5	9
415	39080	14.3464	4	6	11	18	28
416	184735	7.3935	2	4	6	9	14
417	18	5.0000	1	2	4	7	9
418	23026	6.1212	2	3	5	7	11
419	15460	4.7254	2	2	4	6	9
420	3116	3.4881	1	2	3	4	6
421	11535	3.7877	1	2	3	5	7
422	83	3.0482	1	2	3	4	6
423	7539	8.1108	2	3	6	10	16
424	1308	13.6338	2	5	9	16	26
425	15852	3.9953	1	2	3	5	8
426	4552	4.4512	1	2	3	5	9
427	1669	4.6207	1	2	3	6	9
428	854	6.9859	1	2	4	8	14
429	26786	6.3438	2	3	5	7	12
430	59892	8.0207	2	3	6	10	16
431	319	6.4326	1	3	5	7	12
432	475	4.7684	1	2	3	5	9
433	5522	3.0996	1	1	2	4	6
439	1356	8.3857	1	3	5	10	18
440	5191	9.0326	2	3	6	11	20
441	604	3.2235	1	1	2	4	7
442	15588	8.4766	1	3	6	10	18
443	3743	3.4320	1	1	3	4	7
444	5303	4.1495	1	2	3	5	8
445	2450	2.8857	1	1	2	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
447	5497	2.4708	1	1	2	3	5
449	28365	3.7491	1	1	3	5	8
450	6934	1.9980	1	1	1	2	4
451	3	1.3333	1	1	1	2	2
452	22930	4.8560	1	2	3	6	10
453	5091	2.7969	1	1	2	3	5
454	4001	4.5431	1	2	3	5	9
455	939	2.5751	1	1	2	3	5
461	3676	4.3708	1	1	2	5	11
462	13083	11.2728	4	6	10	14	21
463	22068	4.1282	1	2	3	5	8
464	6542	3.0011	1	1	2	4	6
465	248	3.0202	1	1	2	4	6
466	1741	3.7030	1	1	2	4	8
467	1137	3.0633	1	1	2	3	6
468	55027	12.8995	3	6	10	16	26
471	11720	5.5506	3	4	4	6	9
473	7663	12.5910	1	3	7	18	32
475	107894	11.2229	2	5	9	15	22
476	4151	10.8829	2	5	9	14	21
477	25363	8.1252	1	3	6	11	17
478	108182	7.2900	1	3	5	9	15
479	24051	3.4569	1	1	3	4	7
480	562	20.9609	7	9	14	25	44
481	383	24.1253	10	18	22	27	39
482	5737	12.9796	4	7	10	15	25
483	42789	39.4482	14	22	33	49	71
484	331	13.0091	2	6	10	17	26
485	2959	9.7080	4	5	7	11	18
486	2017	12.4408	1	5	10	16	25
487	3506	7.3945	1	3	6	10	15
488	784	16.9031	3	7	12	22	36
489	14140	8.4372	2	3	6	10	17
490	5454	5.3577	1	2	4	6	11
491	12291	3.4475	2	2	3	4	6
492	2698	15.6675	3	5	8	25	34
493	55279	5.7576	1	3	5	7	11
494	30109	2.4447	1	1	2	3	5
495	159	15.0503	7	9	12	17	26
496	1504	9.7088	4	5	7	12	19
497	17585	6.5739	3	4	5	7	11
498	12931	4.1718	2	3	4	5	6
499	30519	4.7011	1	2	3	6	9
500	44330	2.6104	1	1	2	3	5
501	2200	10.9600	4	6	8	13	21
502	585	6.5692	3	4	5	8	11
503	5630	4.0014	1	2	3	5	7
504	118	30.5169	9	15	24	41	55
505	145	3.3517	1	1	1	3	7
506	931	17.4071	4	8	14	22	36
507	293	8.3379	2	4	7	11	18
508	671	7.4918	2	3	5	9	15
509	177	4.5367	1	2	4	6	9
510	1650	7.2358	2	3	5	9	15
511	608	4.8158	1	2	3	6	11
512	340	13.8971	7	8	11	16	25
513	115	10.6000	6	7	8	11	19
514	17025	7.8702	2	3	6	10	16
515	3788	5.9060	1	1	4	8	13
516	68886	4.7702	2	3	4	6	9
517	171423	2.6737	1	1	2	3	6
518	48733	3.5023	1	1	2	4	8
519	6359	5.1030	1	2	3	6	12
520	9489	2.1653	1	1	2	3	4
521	28014	5.9437	2	3	4	7	12
522	6852	9.4658	3	5	8	12	20
523	14954	4.0942	1	2	3	5	7
	11094323						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 2001

State	Urban	Rural
ALABAMA	0.343	0.410
ALASKA	0.417	0.697
ARIZONA	0.355	0.493
ARKANSAS	0.466	0.445
CALIFORNIA	0.339	0.432
COLORADO	0.422	0.577
CONNECTICUT	0.497	0.506
DELAWARE	0.511	0.450
DISTRICT OF COLUMBIA	0.421	.....
FLORIDA	0.351	0.370
GEORGIA	0.461	0.469
HAWAII	0.412	0.549
IDAHO	0.541	0.561
ILLINOIS	0.404	0.501
INDIANA	0.524	0.533
IOWA	0.486	0.613
KANSAS	0.415	0.637
KENTUCKY	0.479	0.492
LOUISIANA	0.401	0.491
MAINE	0.614	0.540
MARYLAND	0.759	0.819
MASSACHUSETTS	0.511	0.571
MICHIGAN	0.459	0.563
MINNESOTA	0.493	0.592
MISSISSIPPI	0.452	0.446
MISSOURI	0.404	0.475
MONTANA	0.537	0.588
NEBRASKA	0.448	0.610
NEVADA	0.306	0.503
NEW HAMPSHIRE	0.549	0.585
NEW JERSEY	0.394	.....
NEW MEXICO	0.466	0.491
NEW YORK	0.524	0.607
NORTH CAROLINA	0.517	0.463
NORTH DAKOTA	0.620	0.655
OHIO	0.500	0.568
OKLAHOMA	0.409	0.492
OREGON	0.614	0.598
PENNSYLVANIA	0.398	0.526
PUERTO RICO	0.486	0.584
RHODE ISLAND	0.510	.....
SOUTH CAROLINA	0.440	0.463
SOUTH DAKOTA	0.529	0.640
TENNESSEE	0.438	0.453
TEXAS	0.401	0.493
UTAH	0.497	0.582
VERMONT	0.572	0.599
VIRGINIA	0.459	0.496
WASHINGTON	0.582	0.639
WEST VIRGINIA	0.568	0.527
WISCONSIN	0.524	0.613
WYOMING	0.523	0.717

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2001

State	Ratio
ALABAMA	0.044
ALASKA	0.058
ARIZONA	0.038
ARKANSAS	0.049
CALIFORNIA	0.034
COLORADO	0.045
CONNECTICUT	0.036
DELAWARE	0.051

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2001—Continued

State	Ratio
DISTRICT OF COLUMBIA	0.035
FLORIDA	0.043
GEORGIA	0.051
HAWAII	0.038
IDAHO	0.046
ILLINOIS	0.040
INDIANA	0.056
IOWA	0.049
KANSAS	0.050
KENTUCKY	0.046
LOUISIANA	0.047
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.053
MICHIGAN	0.044
MINNESOTA	0.047
MISSISSIPPI	0.044
MISSOURI	0.044
MONTANA	0.053
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.061
NEW JERSEY	0.036
NEW MEXICO	0.045
NEW YORK	0.051
NORTH CAROLINA	0.046
NORTH DAKOTA	0.074
OHIO	0.047
OKLAHOMA	0.046
OREGON	0.046
PENNSYLVANIA	0.039
PUERTO RICO	0.045
RHODE ISLAND	0.029
SOUTH CAROLINA	0.046
SOUTH DAKOTA	0.059
TENNESSEE	0.048
TEXAS	0.046
UTAH	0.047
VERMONT	0.052
VIRGINIA	0.055
WASHINGTON	0.063
WEST VIRGINIA	0.045
WISCONSIN	0.051
WYOMING	0.065

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a final rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities. We estimate the total impact of these changes for FY 2002 payments compared to FY 2001 payments to be approximately a $1.9 billion increase. As such, this final rule is a major rule as defined in 5 U.S.C. 804(2). Therefore, we have prepared an impact analysis for this final rule.

Also, 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. Such an analysis must conform to the provisions of section 603 of the RFA. 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 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that the final rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

Section 202 of the Unfunded Mandate Reform Act of 1995 (Public Law 104–4) also requires that agencies assess anticipated costs and benefits before issuing any final rule that has been preceded by a final 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 would not mandate any requirements for 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.

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the inpatient prospective payment system and hospitals and units excluded from the system have both risen by 0.2 percentage points. As a result, the updates are 0.2 percentage points higher than the updates reflected in the impact analysis for the proposed rule. With the exception of these changes, we are generally implementing the policy and

statutory provisions discussed in the proposed rule.

III. Impact Analysis for CMS–1131–F and CMS–1178–F

As noted previously, this final rule contains provisions implemented in two interim final rules with comment periods. The first, published August 1, 2000 (65 FR 47026), implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106–113. The second, published June 13, 2001 (66 FR 32172), implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106–554.

As described in the preamble to this final rule, with the exception of minor changes to the process for receiving, reviewing, and approving new Medicare-dependent small rural hospitals (MDHs), we are not changing the policies described in those interim final rules with comment period. Therefore, the reader should refer to the impact analyses contained in those interim final rules for a discussion of the impacts of these changes. For the impact analysis in the August 1, 2000 interim final rule, the reader should refer to page 47043. For the impact analysis in the June 13, 2001 interim final rule, the reader should refer to page 32184.

IV. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, including statutory changes effective for FY 2002, 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. We received two comments on the impact analysis for our May 4, 2001 proposed rule.

Comment: One commenter, who was unable to reconcile the standardized amounts for FY 2002 proposed in the May 4, 2001 **Federal Register** with the standardized amounts published for FY 2001 (65 FR 47126 and 66 FR 32176), expressed concern with the level of detail provided by the impact analysis and requested a breakdown of the changes reflected in Column 8 of Table 1. The commenter also requested that we release the complete data so that hospitals could evaluate all the proposed FY 2002 policy changes on their own.

Response: As we stated in the proposed rule, column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2002 (including statutory changes), to our estimate of payments per case in FY 2001. It includes the effects of the 2.75 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.1 percentage point difference between the projected percentage of outlier payments in FY 2001 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2001 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule. Additionally, there are differences resulting from the increased number of hospitals receiving DSH payments under Section 211 of Public Law 106–554 and from the increase in SCH rebasing to a 1996 blended rate. There are also interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 7 may not equal the sum of the changes in columns 5 and 6, plus the other impacts that we are able to identify. Since we explain the update for FY 2002 in section II. of the Addendum of this final rule, and since the impact of those changes are the same for all types of hospitals, we do not believe it is necessary to isolate that change in a separate impact column. Also, we would like to note that all of the data used by us in the impact analysis are available to the public. Our impact file is posted on our website following the publication of each proposed and final rule. For information on obtaining the MedPAR file, the Provider-Specific File, and the cost report files on which all of our analysis is based, we refer the reader to section VIII. of this final rule.

Comment: One commenter noted that, in the proposed rule, the budget neutrality factor in footnote 6 of Table 1 was printed as 0.992394 while the same factor was printed as 0.992493 on page 22872 and asked which factor was correct.

Response: Footnote 6 to Table 1 in the proposed rule contained a typographical error. The budget neutrality factor used in the proposed rule was 0.992493 and was printed correctly on page 22872 of the proposed rule.

V. Hospitals Included in and Excluded From the Prospective Payment System

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 48 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. We also exclude critical access hospitals (CAHs) from our analysis, due to the special characteristics of these hospitals. Among other short-term, acute care hospitals, only the 68 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of July 2001, we have included 4,795 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.

The remaining 20 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

VI. Impact on Excluded Hospitals and Units

As of July 2001, there were 1,064 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 507 psychiatric, 210 rehabilitation, 260 long-term care, 77 children's, and 10 cancer hospitals. In addition, there were 1,446 psychiatric units and 926 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 68 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded

hospitals and units for FY 2002 would be between 0.8 and 3.3 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and 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 percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and 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 units to restrain the growth in their spending for patient services.

VII. Graduate Medical Education Impact

A. National Average Per Resident Amount (PRA)

As discussed in detail in section IV.H.2. of this proposed rule, we proposed to implement section 511 of Public Law 106–554, which increased the floor of the locality-adjusted national average (PRA for the purposes of computing direct GME payments for cost reporting periods beginning during FY 2002. The national average PRA payment methodology, as provided in section 311 of Public Law 106–113, establishes a ''floor'' and ''ceiling'' based on a locality-adjusted, updated national average PRA for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2005. Section 511 of Public Law 106–554 increased the floor from 70 percent to equal 85 percent of a locality-adjusted national average PRA for FY 2002.

For this final rule, we have calculated an estimated impact of this policy on teaching hospitals' PRAs for FY 2002, making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, using FY 1997 data, we calculated a floor based on 70 percent of the national average PRA and a floor based on 85 percent of the national average PRA. We then determined the amount of direct GME payments that would have been paid had the floor remained at 70 percent of the national average PRA. Next, we determined the amount of direct GME payments that would be paid with the floor increased to equal 85 percent of the national average PRA. We subtracted the difference between the two and inflated the difference to FY 2002 to determine the impact of this provision.

The figures we used in this impact, except for the FY 1997 weighted PRA of $68,464, are estimations and are for demonstrative purposes only. Hospitals must use the methodology stated in section IV.H. of this final rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we used Medicare cost report data for all cost reports ending in FY 1997. We excluded hospitals that file manual cost reports because we did not have access to their Medicare utilization data. We also excluded all teaching hospitals in Maryland, because these hospitals are paid on a Medicare waiver outside of the prospective payment system, and those hospitals' PRAs do not determine their level of direct GME payments. For hospitals that had two cost reporting periods ending in FY 1997, we used the later of the two periods. A total of 1,231 teaching hospitals were included in the analysis.

Using the FY 1997 weighted average PRA of $68,464, we determined an 85 percent floor of $58,194 for FY 1997. We then determined that, for cost reporting periods ending in FY 1997, approximately 562 hospitals had PRAs that were below $58,194 (336 hospitals of these hospitals had PRAs that were below the 70-percent floor, and 226 hospitals had PRAs that were above the 70-percent floor but below the 85-percent floor). The estimated total cost to the Medicare program in FY 2002 of replacing the PRAs of the 562 hospitals with the 85-percent floor is $105.3 million.

B. Closed Training Programs or Hospitals That Close Their Training Programs

As discussed in IV.H.5, of the preamble of this final rule, we are allowing a hospital to receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's GME program if the hospital that closed its program agrees to temporarily reduce its FTE cap. We have calculated an estimated impact on the Medicare program for FY 2002 as a result of this policy. We used the best available cost report data from the FY 1997 HCRIS in our analysis.

We estimate that approximately 5 to 10 programs, each with an average of 25 residents, close each year without advance warning, displacing the residents before they complete their training. Therefore, the number of residents displaced each year could be between 125 and 250. We estimated the impact of this change based on direct GME and IME payment amounts in FY 1997 to determine a total GME amount and updated the total with the CPI–U for FY 2002. At most, the estimated impact for this provision for FY 2002 is moving payments of between $10 and $20 million among different hospitals. This would result from redirecting these payments from the hospital that closed its program to the hospital(s) that takes on the residents.

VIII. Quantitative Impact Analysis of the Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the final changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the March 2001 update of the FY 2000 MedPAR file and the most current Provider Specific File that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data 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. Second, due to the

interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each final 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 sources overall. For individual hospitals, however, some miscategorizations are possible.

Using cases from the March, 2001 update of the FY 2000 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of FY 2002 policy changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 1998, compared to the FY 1997 wage data.
- The effects of our final policy to increase the accuracy of the wage index calculation by changing the overhead allocation method used so that the salaries and hours of lower-wage, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital are more accurately removed when calculating the overhead costs attributable to wages.
- The effects of our final policy to include the contract labor costs of laboratories and pharmacies from Worksheet S–3 Part II Lines 9.01 and 9.02 in the wage index calculation.
- The combined effects of our changes to the wage index data and calculations and the changes in the DRG recalibration.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2002.
- The effects of our new policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.
- The total change in payments based on FY 2002 policies relative to payments based on FY 2001 policies.

To illustrate the impacts of the FY 2002 final changes, our analysis begins with a FY 2002 baseline simulation model using: the FY 2001 DRG GROUPER (version 18.0); the FY 2001 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2002 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2001 to FY 2002. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, as amended by section 301 of Public Law 106–554, we updated the large urban and the other areas average standardized amounts for FY 2002 using the most recently forecasted hospital market basket increase for FY 2002 of 3.3 percent minus 0.55 percentage points (for an update of 2.75 percent). Under section 1886(b)(3) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for MDHs are equal to the market basket increase of 3.3 percent minus 0.55 percentage points (for an update of 2.75 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2001 to FY 2002 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2001 that are no longer reclassified in FY 2002 may have a negative payment impact going from FY 2001 to FY 2002; conversely, hospitals not reclassified in FY 2001 that are reclassified in FY 2002 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. This effect may be alleviated somewhat by section 304(a) of Public Law 106–554, which provided 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 2001 will be 6.2 percent of actual total DRG payments. When the FY 2001 final rule was published, we projected FY 2001 outlier payments would be 5.1 percent of total DRG plus outlier payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2001 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2001 payments per case to estimated FY 2002 payments per case.

Fourth, section 213 of Public Law 106–554 provided 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 2002, eligible SCHs that are rebased receive a hospital-specific rate comprised of the greater of 50-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or 50-percent of the federal rate, and 50-percent of their FY 1996 hospital-specific rate.

Fifth, sections 302 and 303 of Public Law 106–554 affect payments for indirect medical education (IME) and disproportionate share hospitals (DSH), respectively. These sections increased IME and DSH payments during FY 2001 (effective with discharges on or after April 1, 2001). For FY 2002, section 302 established IME payments at the same level as FY 2001 (6.5 percent), and section 303 established DSH payments at the adjustment the hospital would otherwise receive minus 3 percent.

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 4,795 hospitals included in the analysis. This number is 93 fewer hospitals than were included in the impact analysis in the FY 2001 final rule (65 FR 47191).

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 2,704 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,561 hospitals located in large urban areas (populations over 1 million), and 1,143 hospitals in other urban areas (populations of 1 million or fewer). In

addition, there are 2,091 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 2002 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 2,746, 1,632, 1,114, and 2,049, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,668 non-teaching hospitals in our analysis, 890 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. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) We note that section 211 of Public Law 106–554 reduced the qualifying DSH threshold to 15 percent for all hospitals (this threshold previously applied to urban hospitals with 100 or more beds and rural hospitals with 500 or more beds). Consequently, many more hospitals qualify for DSH. In the FY 2001 final rule, there were 3,070 hospitals that did not receive a DSH adjustment (65 FR 47192). In Table I, the number of hospitals that did not receive a DSH adjustment declines to 1,879. The number of urban hospitals with fewer than 100 beds receiving DSH increases from 72 prior to section 211 to 316 after its implementation. Among rural hospitals with fewer than 100 beds, 103 received DSH prior to section 211; for FY 2002 that number increases to 454.

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 (165), SCHs (680), MDHs (329), and SCH and RRCs (70) shown here were not reclassified for purposes of the standardized amount. There are 15 RRCs, 1 MDH, 4 SCHs, and 1 SCH and RRC that will be reclassified as urban for the standardized amount in FY 2002 and, therefore, are not included in these rows.

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 1999 Medicare cost report files, if available (otherwise FY 1998 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 52 and 78 hospitals, respectively. For the most part, these appear to be new hospitals, without cost reports on file for FY 1999.

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 2002. 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 CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Num. of hosps.[1]	DRG re-calib.[2]	New wage data[3]	New overhead alloc.[4]	Include contract labor[5]	DRG & WI changes[6]	MCGRB reclassi-fication[7]	Reclassi-fication hold-harmless policy[8]	All FY 2002 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
By Geographic Location									
All hospitals	4,795	0.3	0.2	−0.1	−0.1	0.0	−0.2	0.2	2.1
Urban hospitals	2,704	0.3	0.2	−0.1	−0.1	0.0	−0.7	0.2	1.9
Large urban areas(populations over 1 million)	1,561	0.4	0.0	−0.1	−0.1	−0.1	−0.8	0.3	1.8
Other urban areas (populations of 1 million or fewer)	1,143	0.2	0.5	−0.2	−0.1	0.2	−0.5	0.1	2.0
Rural hospitals	2,091	0.0	0.0	0.2	0.2	−0.2	2.6	0.0	3.4
Bed Size (Urban):									
0–99 beds	695	−0.1	0.1	0.1	0.1	0.0	−0.8	0.2	2.6
100–199 beds	948	0.3	−0.1	0.2	0.2	0.0	−0.7	0.3	2.1
200–299 beds	529	0.3	0.2	0.0	0.0	0.1	−0.7	0.3	2.0
300–499 beds	383	0.3	0.4	−0.3	−0.2	0.0	−0.7	0.2	1.8
500 or more beds	149	0.5	0.4	−0.4	−0.4	0.0	−0.6	0.1	1.6
Bed Size (Rural):									
0–49 beds	1,226	−0.2	0.1	0.2	0.1	−0.3	0.3	0.0	3.4
50–99 beds	520	−0.1	0.0	0.2	0.1	−0.3	1.0	0.0	3.5
100–149 beds	203	0.0	0.0	0.3	0.2	−0.1	3.3	0.1	3.4
150–199 beds	75	0.1	−0.2	0.2	0.2	−0.2	5.2	0.0	3.6
200 or more beds	67	0.1	−0.1	0.1	0.1	−0.2	4.8	0.0	3.3
Urban by Region:									
New England	138	0.3	1.6	−0.3	−0.2	1.2	−0.3	0.2	3.0
Middle Atlantic	416	0.4	−0.5	0.0	0.1	−0.4	−0.7	0.6	1.3
South Atlantic	393	0.4	0.5	−0.1	−0.1	0.4	−0.8	0.3	2.4
East North Central	459	0.2	0.1	−0.2	−0.2	−0.3	−0.5	0.1	1.7
East South Central	160	0.3	1.0	−0.1	−0.1	0.8	−0.7	0.0	3.0
West North Central	187	0.2	0.4	−0.3	−0.3	−0.1	−0.7	0.0	1.7
West South Central	340	0.3	−0.2	−0.2	−0.1	−0.4	−0.7	0.0	1.3
Mountain	136	0.2	0.8	−0.3	−0.3	0.3	−0.7	0.0	2.2
Pacific	429	0.5	0.0	0.1	0.1	0.1	−0.8	0.3	1.9

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Num. of hosps.[1]	DRG re-calib.[2]	New wage data[3]	New overhead alloc.[4]	Include contract labor[5]	DRG & WI changes[6]	MCGRB reclassi-fication[7]	Reclassi-fication hold-harmless policy[8]	All FY 2002 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Puerto Rico	46	0.1	2.1	−0.8	−0.9	1.1	−0.8	0.2	3.3
Rural by Region:									
New England	50	0.0	0.0	0.1	0.1	−0.3	2.9	0.0	3.7
Middle Atlantic	75	0.1	0.1	0.1	0.1	−0.1	2.3	0.0	3.2
South Atlantic	269	0.1	−0.1	0.2	0.2	−0.2	2.9	0.0	3.6
East North Central	276	−0.2	0.0	0.1	0.2	−0.4	2.2	0.0	2.9
East South Central	263	0.0	−0.1	0.2	0.2	−0.2	3.2	0.0	3.7
West North Central	481	−0.3	0.3	0.2	0.1	−0.1	1.8	0.0	2.6
West South Central	333	0.0	0.3	0.2	0.2	0.1	3.6	0.0	4.8
Mountain	195	0.0	−0.1	0.2	0.1	−0.3	1.7	0.0	3.0
Pacific	144	0.1	−0.9	0.2	0.2	−0.9	2.3	0.0	2.8
Puerto Rico	5	−0.3	6.1	0.2	0.1	5.6	−0.7	0.2	9.9
By Payment Classification:									
Urban hospitals	2,746	0.3	0.2	−0.1	−0.1	0.0	−0.6	0.2	1.9
Large urban hospitals (populations over 1 million)	1,632	0.4	0.0	−0.1	−0.1	−0.1	−0.7	0.3	1.9
Other urban hospitals (populations of 1 million or fewer)	1,114	0.2	0.5	−0.2	−0.1	0.2	−0.5	0.1	2.0
Rural hospitals	2,049	0.0	0.0	0.2	0.2	−0.2	2.4	0.0	3.4
Teaching Status:.									
Non-teaching	3,668	0.1	0.0	0.2	0.2	0.0	0.2	0.2	2.4
Fewer than 100 Residents	890	0.2	0.4	−0.2	−0.1	0.1	−0.6	0.2	2.0
100 or more Residents	237	0.6	0.3	−0.5	−0.4	0.0	−0.5	0.1	1.7
Urban DSH:									
Non DSH	1,879	0.1	0.2	−0.1	−0.1	−0.1	−0.1	0.2	1.9
100 or more beds	1,379	0.4	0.2	−0.1	−0.1	0.1	−0.7	0.2	1.9
Less than 100 beds	316	0.1	−0.1	0.3	0.3	0.0	−0.7	0.2	4.0
Rural DSH:									
Sole Community (SCH)	545	0.0	0.0	0.1	0.1	−0.3	0.3	0.0	3.1
Referral Center (RRC)	152	0.2	−0.1	0.2	0.2	−0.1	5.2	0.0	3.8
Other Rural:									
100 or more beds	70	0.0	0.1	0.3	0.3	0.1	1.5	0.1	3.7
Less than 100 beds	454	−0.1	−0.1	0.2	0.2	−0.4	0.6	0.0	4.5
Urban teaching and DSH:									
Both teaching and DSH	758	0.5	0.3	−0.3	−0.2	0.1	−0.7	0.2	1.9
Teaching and no DSH	298	0.2	0.4	−0.3	−0.3	−0.1	−0.5	0.3	1.8
No teaching and DSH	937	0.3	0.0	0.2	0.2	0.1	−0.6	0.2	2.2
No teaching and no DSH	753	0.1	−0.1	0.1	0.1	−0.1	−0.6	0.2	1.8
Rural Hospital Types:									
Non-special status	805	−0.2	0.0	0.3	0.2	−0.2	0.9	0.0	3.8
RRC	165	0.1	−0.1	0.2	0.2	−0.1	6.3	0.1	3.7
SCH	680	0.0	0.0	0.1	0.1	−0.3	0.3	0.0	2.7
Medicare-dependent hospitals (MDH)	329	−0.2	0.2	0.1	0.1	−0.2	0.4	0.0	3.6
SCH and RRC	70	0.0	0.0	0.1	0.1	−0.3	2.1	0.0	2.9
Type of Ownership:									
Voluntary	2,765	0.3	0.1	−0.1	−0.1	−0.1	−0.3	0.2	2.0
Proprietary	717	0.3	0.1	0.0	0.0	0.1	0.0	0.1	2.4
Government	1,261	0.3	0.4	−0.1	0.0	0.3	0.0	0.0	0.0
Unknown	52	−0.4	0.6	0.1	0.1	−0.1	−1.8	1.0	1.6
Medicare Utilization as a Percent of Inpatient Days:									
0–25	396	0.7	0.2	0.0	0.0	0.5	−0.4	0.2	2.5
25–50	1,886	0.4	0.2	−0.2	−0.2	0.0	−0.6	0.2	1.9
50–65	1,843	0.1	0.2	0.0	0.0	0.0	0.1	0.2	2.4
Over 65	592	0.1	−0.2	0.2	0.2	−0.1	0.3	0.2	2.2
Unknown	78	0.3	−0.3	−0.1	0.0	−0.6	0.8	0.2	0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:									
All Reclassified Hospitals	628	0.2	0.2	0.0	0.0	0.0	5.0	0.1	3.3
Standardized Amount Only	74	0.1	−0.4	0.3	0.4	−0.3	2.2	0.4	3.8
Wage Index Only	391	0.2	0.0	0.0	0.0	−0.1	5.5	0.1	2.8
Both	58	0.2	0.3	0.1	0.1	0.1	5.1	0.0	0.6
All Nonreclassified Hospitals	4,246	0.3	0.2	−0.1	0.1	0.0	0.8	0.2	2.1
All Reclassified UrbanHospitals	117	0.4	0.7	−0.3	−0.3	0.2	4.2	0.1	2.6
Standardized Amount Only	14	0.2	−0.3	0.5	0.5	−0.1	0.4	0.3	2.6
Wage Index Only	83	0.4	0.7	−0.5	−0.4	0.2	4.5	0.1	2.4
Both	20	0.2	0.7	0.2	0.3	0.8	4.7	0.5	3.5
Urban Nonreclassified Hospitals	2,549	0.3	0.2	−0.1	−0.1	0.0	−1.0	0.2	1.8
Reclassified Rural Hospitals	511	0.1	0.0	0.2	0.2	−0.2	5.5	0.0	3.7
Standardized Amount Only	16	0.0	−0.1	0.2	0.2	−0.3	3.8	0.0	2.3
Wage Index Only	472	0.1	0.0	0.2	0.2	−0.2	5.3	0.0	3.7
Both	23	0.0	0.2	0.1	0.1	−0.1	9.3	0.0	4.0
Rural Nonreclassified Hospitals	1,577	−0.1	0.0	0.2	0.1	−0.3	−0.6	0.0	3.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
[Percent changes in payments per case]

	Num. of hosps. [1]	DRG re-calib.[2]	New wage data [3]	New overhead alloc.[4]	Include contract labor [5]	DRG & WI changes [6]	MCGRB reclassi-fication [7]	Reclassi-fication hold-harmless policy [8]	All FY 2002 changes [9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Other Reclassified Hospitals (Section 1886(D)(8)(B)) ..	41	0.1	0.6	0.1	0.1	0.4	0.8	−0.7	4.2

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2000, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 2000 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1998 cost reports.

[4] This column displays the impact of removing the salaries and hours of lower-wage, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital from the wage index calculation.

[5] This column displays the impact of including contract pharmacy and contract laboratory costs and hours in the wage index calculation.

[6] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, the revised overhead allocation, the laboratory and pharmacy contract labor costs, and the budget neutrality adjustment factor for these two 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 1, 2, 3, and 4, and the FY 2002 budget neutrality factor of .995821.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2002 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2002. Reclassification for prior years has no bearing on the payment impacts shown here.

[8] Shown here are the effects of our policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

[9] This column shows changes in payments from FY 2001 to FY 2002. It incorporates all of the changes displayed in columns 5, 6, and 7 (the changes displayed in columns 1, 2, 3, and 4 are included in column 5). It also displays the impact of the FY 2002 update, changes in hospitals' reclassification status in FY 2002 compared to FY 2001, and the difference in outlier payments from FY 2001 to FY 2002. It also reflects section 213 of Public law 106–554, which permitted all SCHs to rebase for a 1996 hospital-specific rate. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Final Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 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 to annually 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 2001 DRG relative weights (GROUPER version 18) to aggregate payments using the final FY 2002 DRG relative weights (GROUPER version 19). Overall payments increase 0.3 percent due to the DRG reclassification and recalibration. 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 (and wage index) changes is budget neutral. This budget neutrality factor of 0.995821 is applied to payments in Column 5.

We estimate that the DRG changes effective with this final rule would result in higher payments to urban hospitals (0.3 percent) and would have a 0 percent impact on payments to rural hospitals. The changes also would result in higher payments to larger hospitals than to smaller hospitals. This impact is consistent for both urban and rural bed size groups.

This distributional impact likely results from the final changes to major diagnostic category (MDC) 5 ''Diseases and Disorders of the Circulatory System.'' As described in section II. of the preamble of this final rule, we are removing cardiac defibrillator cases from DRGs 104 and 105, and creating two new DRGs for these cases. In addition, we are revising the basis of the DRG assignment for cases involving percutaneous transluminal coronary angioplasty based on whether the patient experienced an acute myocardial infarction. Because MDC 5 is a high volume category, refining the categorizations of these cases has a noticeable overall payment impact.

C. Impact of Updating the Wage Data and the Final Changes to the Wage Index Calculation (Columns 2, 3 & 4)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the final wage index for FY 2002 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1997 and before October 1, 1998. As with column 1, the impact of the new data on hospital payments is isolated in column 2 by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 2001 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY 2002 prereclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1998 cost reports are similar to the data used in the calculation of the FY 2001 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B. of the preamble of this final rule. The July 30, 1999 final rule (64 FR 41505) indicated that we would phase-out costs related to GME and certified registered nurse anesthestists (CRNA) from the calculation of the wage index over a 5-year period, beginning in FY 2000. The FY 2001 wage index was based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs. For FY 2002, the wage index is based on a blend of 40 percent of an average hourly wage including these costs, and 60 percent of an average hourly wage excluding these costs. This change is reflected in column 2.

The results indicate that the new wage data are estimated to provide a 0.2 percent increase for hospital payments overall (prior to applying the budget neutrality factor, see column 5). In some cases, the results shown in this final rule may be very different from the impacts shown in the proposed rule. This is due to the large number of data revisions submitted by hospitals after the proposed wage index was calculated. Approximately 30 percent of hospitals submitted revisions in the interim.

Rural hospitals are generally estimated to experience a negligible

impact from the new wage data, although rural hospitals in Puerto Rico experience a 6.1 percent increase, likely due to the 13 percent increase in the value of five providers' FY 2002 wage index compared to the wage index for those same providers for FY 2001. Additionally, rural hospitals in West North Central and West South Central experience estimated wage index-driven increases of more than 0.3 percent. Meanwhile, hospitals in the Pacific census division experience a 0.9 percent decrease.

Urban hospitals as a group are estimated to benefit positively from the updated wage data. The other urban hospitals appear to experience a 0.5 percent increase and estimated payments to urban hospitals overall showed an increase of 0.2 percent. Among urban census divisions, Puerto Rico experiences a 2.1 percent increase, the New England division experiences a 1.6 percent increase, East South Central experiences a 1.0 percent increase, and Middle Atlantic a 0.5 percent decrease.

Columns 3 and 4, respectively, show that the final change to the overhead calculation and the policy to include contract labor costs in the wage index discussed in detail in section III.C. of the preamble of this final rule both appear to benefit rural hospitals and small hospitals. Urban hospitals as a group are impacted by a 0.1 percent decrease to their payments from each change. Rural hospitals are expected to receive an estimated 0.2 percent increase in payments due to this policy change.

The following chart compares the shifts in wage index values for labor market areas for FY 2001 relative to FY 2002. This chart demonstrates the impact of the final changes for the FY 2002 wage index relative to the FY 2001 wage index. The majority of labor market areas (335) experience less than a 5-percent change. A total of 28 labor market areas experience an increase of more than 5 percent, with 2 having an increase greater than 10 percent. A total of 11 areas experience decreases of more than 5-percent. Of those, 1 declines by more than 10 percent.

Percentage change in area wage index values	Number of labor market areas	
	FY 2001	FY 2002
Increase more than 10 percent	1	2
Increase more than 5 percent and less than 10 percent	20	26
Increase or decrease less than 5 percent	339	335
Decrease more than 5 percent and less than 10 percent	14	10
Decrease more than 10 percent	1	1

Among urban hospitals, 129 would experience an increase of between 5 and 10 percent, and 3 experience an increase of more than 10 percent. A total of 18 rural hospitals have increases greater than 5 percent, with 5 increasing greater than 10 percent. On the negative side, 29 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Four urban hospitals have decreases in their wage index values greater than 10 percent. There are no rural hospitals with decreases in their wage index values greater than 5 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	3	5
Increase more than 5 percent and less than 10 percent	129	13
Increase or decrease less than 5 percent	2,531	2,166
Decrease more than 5 percent and less than 10 percent	29	0
Decrease more than 10 percent	4	0

D. Combined Impact of DRG and Wage Index Changes— Including Budget Neutrality Adjustment (Column 5)

The impact of 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 2001 DRG relative weights and wage index to simulated aggregate payments using the final FY 2002 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.995821. 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 5. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, 3 and 4, minus approximately 0.4 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

E. Impact of MGCRB Reclassifications (Columns 6 & 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2002. As noted below, these decisions may affect hospitals' standardized amount and wage index area assignments. The changes in column 7 reflect the postreclassified wage index values resulting from including the wage data for a reclassified hospital in both the area to

which it is reclassified and the area where the hospital is physically located.

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 the other area's standardized amount, wage index value, or both.

The final FY 2002 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2002. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process for MGCRB decisions.

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 0.990675 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.) This results in a larger budget neutrality offset than the FY 2001 factor of 0.993187. This larger offset is accounted for by the extension of wage index reclassifications for 3 years as a result of section 304 of Public Law 106–554, and our final policy to hold-harmless the calculation of urban areas' wage indexes for reclassifications out of the area (see column 7). We have identified 162 hospitals that were reclassified for FY 2001, but not FY 2002, that will nonetheless continue to be reclassified due to section 304 of Public Law 106–554.

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.6 percent in column 6. Payments to urban hospitals decline 0.7 percent. Hospitals in other urban areas see a decrease in payments of 0.5 percent, while large urban hospitals lose 0.8 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The largest increases are in the West South Central, East South Central, New England and the South Atlantic regions. These regions receive increases of 3.6, 3.2, and 2.9 and 2.9, respectively. The rural census division for the Puerto Rico region appears to receive an estimated decrease in payments of 0.7 percent.

Among all the hospitals that were reclassified for FY 2002, the MGCRB changes are estimated to provide a 5.0 percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 4.2 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 5.5 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 2.2 percent is expected, while those reclassified for purposes of the wage index only show a 5.5 percent increase in payments. Payments to urban hospitals that did not reclassify are expected to decrease by 1.0 percent due to the budget neutrality of MGCRB changes. 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 0.1 percent.

Column 7 shows the impacts of our final policy to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. This change affects overall payments by 0.2 percent, partially accounting for the larger budget neutrality factor compared to FY 2001. The payment impacts are generally largest in urban hospital groups, with the largest impact, 0.6 percent, experienced by urban hospitals in the Middle Atlantic census division.

F. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2002 (including statutory changes), to our estimate of payments per case in FY 2001. It includes the effects of the 2.75 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.1 percentage point difference between the projected percentage of outlier payments in FY 2001 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2001 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

We also note that section 211 of Public Law 106–554 changed the criteria for hospitals to qualify for DSH payment status. Since more hospitals are now eligible to receive DSH payments for the full FY 2002, as opposed to for just the second 6 months of FY 2001, DSH payments to providers in FY 2002 would increase and this change is also captured in column 8.

Section 213 of Public Law 106–554 provided that all SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2002, eligible SCHs that rebase receive a hospital-specific rate comprised of 50 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their Federal rate, and 50 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes in columns 5, 6, and 7, plus the other impacts that we are able to identify.

Hospitals in urban areas experience a 1.9 percent increase in payments per case compared to FY 2001. The net 0.5 percent negative impact due to reclassification (columns 6 and 7) is offset by a similar negative impact for FY 2001 of 0.4 percent (65 FR 47196). Hospitals in rural areas, meanwhile, experience a 3.4 percent payment increase. This is primarily due to the change in the DSH threshold to 15 percent for all hospitals enacted by section 211 of Public Law 106–554 effective for discharges on or after April 1, 2001, and the positive effect of the reclassification changes (2.6 percent increase).

The impact of lowering the DSH threshold is demonstrated in Column 8, although we would note that the estimated FY 2001 payments do reflect 6 months of payments to hospitals affected by this change. The impacts are seen in the rows displaying urban hospitals with fewer than 100 beds receiving DSH (4.0 percent increase), and all rural DSH categories.

Among urban census divisions, payments increased between 1.3 and 3.3 percent between FY 2001 and FY 2002. The rural census division experiencing the smallest increase in payments was the West North Central region (2.6 percent). The largest increases by rural hospitals is in Puerto Rico, where payments appear to increase by 9.9 percent, and West South Central, where payments appear to increase by 4.8 percent. All 5 of the rural Puerto Rico hospitals experienced an increase of greater than 10 percent in their wage index values (comparison of FY 2001 and FY 2002). Rural New England, East South Central, and South Atlantic regions also benefited with 3.7, 3.7, and 3.6 percent respectively.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 2.7 percent, 3.6 percent, and 2.9 percent, respectively. This outcome is primarily related to the fact that hospitals receiving payments under the hospital-specific methodology are not eligible for outlier payments. Therefore,

these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2001 to FY 2002 (from 6.2 percent of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

Among hospitals that were reclassified for FY 2002, hospitals overall are estimated to receive a 3.3 percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 2.6 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 3.7 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount only, a payment increase of 3.8 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 2.8 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.2 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Num. of hosp. (1)	Average FY 2001 payment per case[1] (2)	Average FY 2002 payment per case[1] (3)	All FY 2002 changes (4)
By Geographic Location	4,795	6,994	7,141	2.1
All hospitals.				
Urban hospitals	2,704	7,559	7,703	1.9
Large urban areas (populations over 1 million)	.....	.....	.....	.....
Other urban areas (populations of 1 million of fewer)	1,143	6,853	6,989	2.0
Rural hospitals	2,091	4,808	4,972	3.4
Bed Size (Urban)	695	5,110	5,246	2.6
0–99 beds	.....	.....	.....	.....
100–199 beds	948	6,313	6,444	2.1
200–299 beds	529	7,218	7,364	2.0
300–499 beds	383	8,139	8,283	1.8
500 or more beds	149	9,875	10,035	1.6
Bed Size (Rural)	1,226	3,984	4,118	3.4
0–49 beds	.....	.....	.....	.....
50–99 beds	520	4,526	4,683	3.5
100–149 beds	203	4,858	5,022	3.4
150–199 beds	75	5,336	5,529	3.6
200 or more beds	67	6,188	6,392	3.3
Urban by Region	138	8,014	8,254	3.0
New England.				
Middle Atlantic	416	8,600	8,713	1.3
South Atlantic	393	7,169	7,338	2.4
East North Central	459	7,215	7,335	1.7
East South Central	160	6,776	6,976	3.0
West North Central	187	7,342	7,470	1.7
West South Central	340	6,998	7,090	1.3
Mountain	136	7,308	7,467	2.2
Pacific	429	8,939	9,109	1.9
Puerto Rico	46	3,207	3,312	3.3
Rural by Region	50	5,740	5,950	3.7
New England	.....	.....	.....	.....
Middle Atlantic	75	5,114	5,277	3.2
South Atlantic	269	4,950	51,128	3.6
East North Central	276	4,813	4,951	2.9
East South Central	263	4,423	4,587	3.7
West North Central	481	4,714	4,839	2.6
West South Central	333	4,249	4,452	4.8
Mountain	195	5,168	5,321	3.0
Pacific	144	6,090	6,263	2.8
Puerto Rico	5	2,521	2,771	9.9
By Payment Classification: Urban hospitals	2,746	7,538	7,682	1.9
Large urban hospitals (populations over 1 million)	1,632	8,026	8,175	1.9
Other urban hospitals (populations of 1 million or fewer)	1,114	6,870	7,006	2.0
Rural hospitals	2,049	4,791	4,954	3.4
Teaching Status	3,668	5,638	5,775	2.4
Non-teaching	.....	.....	.....	.....
Fewer than 100 Residents	890	7,327	7,473	2.0
100 or more Residents	237	11,280	11,473	1.7
Urban DSH	1,879	6,356	6,479	1.9
Non DSH	.....	.....	.....	.....
100 or more beds	1,379	8,152	8,307	1.9
Less than 100 beds	316	4,973	5,173	4.0
Rural DSH	545	4,650	4,796	3.1
Sole Community (SCH)	.....	.....	.....	.....

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Num. of hosp. (1)	Average FY 2001 payment per case[1] (2)	Average FY 2002 payment per case[1] (3)	All FY 2002 changes (4)
Referral Center (RRC)	152	5,542	5,754	3.8
Other Rural	70	4,320	4,479	3.7
100 or more beds	.....	.....	.....	.....
Less than 100 beds	454	3,937	4,115	4.5
Urban teaching and DSH:	.....	.....	.....	.....
Both teaching and DSH	758	9,081	9,250	1.9
Teaching and no DSH	298	7,577	7,715	1.8
No teaching and DSH	937	6,343	6,481	2.2
No teaching and no DSH	753	5,895	6,002	1.8
Rural Hospital Types	.....	.....	.....	.....
Non-special status	805	4,048	4,204	3.8
RRC	165	5,433	5,636	3.7
SCH	680	4,884	5,017	2.7
Medicare-dependent hospitals (MDH)	329	3,852	3,991	3.6
SCH and RRC	70	5,902	6,073	2.9
Type of Ownership: Voluntary	2,341	7,149	7,295	2.1
Proprietary	645	6,641	6,773	2.0
Government	962	6,259	6,437	2.8
Unknown	847	7,151	7,293	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	396	9,564	9,807	2.5
25–50	1,886	8,045	8,195	1.9
50–65	1,843	6,040	6,184	2.4
Over 65	592	5,422	5,543	2.2
Unknown	78	10,360	10,433	0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals	628	6,234	6,438	3.3
Standardized Amount Only	74	5,210	5,409	3.8
Wage Index Only	391	6,103	6,270	2.8
Both	58	6,876	6,919	0.6
All Nonreclassified Hospitals	4,246	7,122	7,269	2.1
All Reclassified Urban Hospitals	117	8,365	8,578	2.6
Standardized Amount Only	14	5,990	6,143	2.6
Wage Index Only	83	9,072	9,294	2.4
Both	20	6,064	6,276	3.5
Urban Nonreclassified Hospitals	2,549	7,539	7,678	1.8
All Reclassified Rural Hospitals	511	5,383	5,584	3.7
Standardized Amount Only	16	5,183	5,302	2.3
Wage Index Only	472	5,387	5,589	3.7
Both	23	5,381	5,597	4.0
Rural Nonreclassified Hospitals	1,577	4,271	4,399	3.0
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	4,838	5,043	4.2

[1] 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 2002 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 2001 with the average estimated per case payments for FY 2002, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

IX. Impact for Critical Access Hospitals (CAHs)

There are approximately 365 facilities that qualify as CAHs. These CAHs are paid based on reasonable costs for their services to inpatients and outpatients. We examined several parts of the final rule, as discussed in detail in section VI.B. of the preamble, for their potential impact on CAHs.

A. Exclusion of CAHs From Payment Window Requirements

In this final rule, we are clarifying the policy that CAHs are not subject to the payment window provisions of section 1886(a)(3) of the Act. Existing regulations do not require application of these provisions to CAHs, and we are not aware of specific situations in which they are now being applied. Consequently, we do not expect any increase or decrease in Medicare spending based on this clarification.

B. Availability of CRNA Pass-Through for CAHs

Under existing § 412.113(c), CRNA pass-through payment is available only to hospitals that either qualified for the pass-through of costs of anesthesia services furnished in calendar year

1989, or met certain conditions, including having employed or contracted with a qualified nonphysician anesthetist as of January 1, 1988, to perform anesthesia services. In this final rule, we are specifying that certain CAHs that meet the pass-through criteria would qualify for pass-through payments. Under the existing criterion, we believe the only facilities that could qualify for the pass-through as CAHs are those that would have qualified for the pass-through if they had elected to continue participating in Medicare as hospitals rather than converting to CAH status. We do not expect any increase or decrease in Medicare spending based on the final change in the regulations.

C. Payment for Emergency Room On-Call Physicians

In accordance with the amendments made by section 204 of Public Law 106–544, in this final rule, we are specifying that we will recognize as allowable costs, amounts for reasonable compensation and related costs for emergency room physicians who are on call but who are not present on the premises of a CAH. We expect that at least some CAHs will elect to compensate emergency room physicians for being on call and that, as a result, Medicare spending for CAH services will increase. However, we do not have information to develop a reliable estimate of how many CAHs will make this election, or how much physician compensation costs they will incur for on call time.

D. Treatment of Ambulance Services Furnished by Certain CAHs

In accordance with the provisions of section 205 of Public Law 106–554, we are amending the existing CAH regulations to provide for payment to CAHs for the reasonable costs of ambulance services furnished by a CAH or an entity owned or operated by the CAH if certain statutory requirements are met. We expect that at least some CAHs or entities owned or operated by CAHs will be able to qualify for payment for their ambulance services. To the extent that CAHs or CAH owned or operated entities furnish these services under the conditions specified in the law, ambulance services will be paid for at higher rates than would otherwise apply. As a result, Medicare spending for ambulance services will increase. However, we do not have sufficient information or data to develop a reliable estimate of how many CAHs or entities will qualify or the dollar amount of ambulance service costs they will incur.

E. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluations in CAHs

As discussed in section VI.B. of this final rule, in an effort to eliminate or minimize potential issues relating to beneficiary access to medical services in rural areas, we are allowing CRNAs who administer the anesthesia to conduct the preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the final change will not permit CRNAs to practice beyond his or her licensed scope of practice.

We believe that this policy will increase flexibility of providers in furnishing medical services in rural areas. However, we do not have information or data to develop a reliable estimate of how many CRNAs would be used to conduct preanesthesia and postanesthesia evaluations in CAHs or what the associated costs would be.

X. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 8th year of the capital prospective payment system (cost reports beginning in FY 1999) available through the March 2001 update of the HCRIS. We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding fiscal intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2002 capital cost projections. In Appendix B of this final rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2002 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2002. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 2002 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 2002 capital costs for individual hospitals, but with the most recent data on hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the FY 2002 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2001 to FY 2002 using a capital cost model. The FY 2002 model, as described in Appendix B of this final rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1999 as reported on the March 2001 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through April 1, 2001 in the provider-specific file. We used these data to determine the FY 2002 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1999, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1999. All Federal rate payment parameters are assigned to the applicable hospital. We will continue to pay regular exceptions during cost reporting periods beginning before October 1, 2001 but ending in FY 2002. However, in FY 2003 and later, payments will no longer be made under the regular exceptions provision; hence, we will no longer require the actuarial model described in Appendix B of this final rule.

For purposes of this impact analysis, the FY 2002 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
2000	1.39
2001	1.37
2002	2.58

- We estimate that the Medicare case-mix index will decrease by 0.9 percent in FY 2001 and will increase by 1.0 percent in FY 2002.
- The Federal capital rate and the hospital-specific rate were 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 2002 update is 1.3 percent (see section IV. of the Addendum to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 2001 to FY 2002. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. We are no longer displaying a column for the hospital-specific payments in Table III since, beginning with FY 2001, the transition blend percentage for fully prospective hospitals is 100 percent of the Federal rate and zero percent of the hospital-specific rate, and all hospitals (except ''new'' hospitals under § 412.324(b)) are paid based on 100 percent of the Federal rate for FY 2002. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2002

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	62	57	61
High Cost Hospital	34	38	43	39

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(c) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 2001 to FY 2002 using the above described actuarial model. With the Federal rate, we estimate aggregate Medicare capital payments will increase by 4.27 percent in FY 2002. This increase is noticeably somewhat lower than last year's (5.48 percent) due in part to the fact that because the transition period ends after FY 2001, there is no longer an increase in the Federal blend percentage, which increased from 90 to 100 percent from FY 2000 to FY 2001, for fully prospective hospitals.

TABLE III.—IMPACT OF CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hold harm-less payment	Exceptions payment	Total payment	Percent change over FY 2001
FY 2001 Payments per Discharge:								
Low Cost Hospitals	3,127	6,769,127	$620.00	99.66	$2.99	$5.30	$628.28	
Fully Prospective	2,942	6,276,252	621.64	100.00		4.89	626.53	
100% Federal Rate	169	456,256	617.75	100.00		6.16	623.91	

TABLE III.—IMPACT OF CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE—Continued

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2001
Hold Harmless	16	36,620	366.68	48.18	552.28	64.01	982.96	
High Cost Hospitals	1,580	4,165,866	632.93	98.07	16.77	9.18	658.87	
100% Federal Rate	1,408	3,837,475	644.77	100.00		7.11	651.88	
Hold Harmless	172	328,391	494.55	75.83	212.71	33.31	740.57	
Total Hospitals	4,707	10,934,994	624.92	99.04	8.24	6.77	639.94	
FY 2002 Payments per Discharge:								
Low Cost Hospitals	3,127	6,877,112	643.74	100.00		2.85	646.59	2.91
Fully Prospective	2,942	6,376,366	643.23	100.00		2.92	646.14	3.13
100% Federal Rate	185	500,747	650.23	100.00		2.07	652.29	4.55
High Cost Hospitals	1,580	4,232,640	667.73	100.00		5.55	673.28	2.19
100% Federal Rate	1,580	4,232,640	667.73	100.00		5.55	673.28	3.28
Total Hospitals	4,707	11,109,753	652.88	100.00		3.88	656.76	2.63

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 2.91 percent, and high capital cost hospitals will experience an average increase of 2.19 percent. These results are due to the fact that there is no longer an increase in the Federal blend percentage with the conclusion of the capital transition period in FY 2001 for fully prospective hospitals. Beginning FY 2002, all hospitals (except ''new'' hospitals under § 412.324(b)) are paid based on 100 percent of the Federal rate for FY 2002.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage remains at 100 percent from FY 2001 (the last year of the transition period) and since they no longer receive payments based on the hospital-specific rate. The Federal rate payment percentage in FY 2001 for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital in FY 2001 will increase from 75.83 percent to 100 percent since the transition period will have ended. All hold-harmless hospitals (except ''new'' hospitals under § 413.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002. We estimate that high cost hospitals (paid based on 100 percent of the Federal rate) will receive a decrease in exceptions payments from $7.11 per discharge in FY 2001 to $5.55 per discharge in FY 2002. This is primarily due to the expiration of the regular exceptions provision in FY 2002.

We are no longer presenting the average hospital-specific rate payment per discharge in Table III because, beginning with FY 2001, the transition blend percentage for fully prospective hospitals is 100 percent of the Federal rate and zero percent of the hospital-specific rate, and all hospitals (except ''new'' hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate for FY 2002.

As stated previously, we will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001, but ending in FY 2002. However, in FY 2003 and later, regular exception payments will no longer be made under the regular exceptions provision but eligible hospitals could receive special exception payments under § 412.348(g).

We estimate that regular exceptions payments will decrease from 1.06 percent of total capital payments in FY 2001 to 0.59 percent of payments in FY 2002. These results are primarily due to the expiration of the regular exceptions after FY 2001 and the limited nature of the special exceptions policy in FY 2002. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2002 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	104	46
High Capital Cost	112	54
Total	216	100

In the past we presented a cross-sectional summary of hospital groupings by the capital prospective payment transition period methodology generated by our actuarial model (Appendix B). We are no longer including such a comparison since all hospitals (except ''new'' hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002 with the conclusion of the 10-year capital transition period.

C. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2002 actuarial model to estimate the potential impact of our changes for FY 2002 on total capital payments per case, using a universe of 4,707 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 2001 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table IV, we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 2002 payment policies. As we explain in Appendix B of this final rule, we were not able to use 88 of the 4,795 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,707 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals. Columns 3 and 4 show estimates of payments per case under our model for FY 2001 and FY 2002, respectively. Column 5 shows the total percentage change in payments from FY 2001 to FY 2002. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 2.28 percent increase in the Federal rate, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change for all hold-harmless hospitals being paid based on 100 percent of the Federal rate, and changes in exception payments. The comparisons are provided by: (1)

geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 2.6 percent in FY 2002. The results show that the effect of the Federal rate change alone is to increase payments by 3.4 percent. In addition to the increase attributable to the Federal rate change, a 0.8 percent decrease is attributable to the effects of all other changes.

Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (2.7 percent and 2.0 percent, respectively). This difference is due to the lower rate of decrease for urban hospitals relative to rural hospitals (0.7 percent and 1.4 percent, respectively) from the effect of all other changes. Urban hospitals will gain the same as rural hospitals (3.4 percent) from the effects of Federal rate changes alone.

Most regions are estimated to receive increases in total capital payments per case, partly due to the fact that payments to all hospitals (except ''new'' hospitals under § 412.324(b)) will be based on 100 percent of the Federal rate in FY 2002. Changes by region vary from a minimum increase of 0.7 percent (Mountain rural region) to a maximum increase of 3.5 percent (East North Central region).

By type of ownership, voluntary hospitals are projected to have the largest rate of increase of total payment changes (2.8 percent, a 3.4 percent increase due to the Federal rate changes, and a 0.6 percent decrease from the effects of all other changes). Similarly, payments to government hospitals will increase 2.2 percent (a 3.4 percent increase due to Federal rate changes, and a 1.2 percent decrease from the effects of all other changes), while payments to proprietary hospitals will increase 0.9 percent (a 3.3 percent increase due to Federal rate changes, and a 2.4 percent decrease from the effects of all other changes). This 2.4 percent decrease from all other changes is primarily due to the estimated decrease in exceptions payments and the change for all hold-harmless hospitals being paid based on 100 percent of the Federal rate.

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 and for purposes of DSH for FYs 1999 through 2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2002 compared to the effects of reclassification for FY 2001, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2002 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2002 as a whole are projected to experience a 2.5 percent increase in payments (a 3.4 percent increase attributable to Federal rate changes and a 0.9 percent decrease attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly more (2.6 percent) than reclassified hospitals (2.5 percent) overall. Payments to nonreclassified hospitals will increase the same as reclassified hospitals from the Federal rate changes (3.4 percent), and they will lose slightly less from the effects of all other changes (0.8 percent compared to 0.9 percent, respectively).

TABLE IV.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2001 Payments compared to FY 2002 payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All charges	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,707	640	657	2.6	3.4
Large urban areas (populations over 1 million)	1,518	742	763	2.9	3.4
Other urban areas (populations of 1 million fewer)	1,110	629	645	2.5	3.4
Rural areas	2,079	433	442	2.0	3.4
Urban hospitals	2,628	693	712	2.7	3.4
0–99 beds	638	504	501	-0.6	3.2
100–199 beds	932	591	604	2.3	3.3
200–299 beds	527	662	681	2.9	3.4
300–499 beds	382	734	757	3.2	3.4
500 or more beds	149	890	917	3.0	3.4
Rural hospitals	2,079	433	442	2.0	3.4
0–49 beds	1,218	364	371	1.7	3.3
50–99 beds	516	406	414	1.9	3.3
100–149 beds	203	443	450	1.8	3.4
150–199 beds	75	482	494	2.4	3.3
200 or more beds	67	541	553	2.2	3.4
By Region:					
Urban by Region	2,628	693	712	2.7	3.4
New England	137	733	757	3.4	3.5
Middle Atlantic	406	776	797	2.6	3.3
South Atlantic	391	665	682	2.5	3.4
East North Central	445	666	690	3.5	3.4
East South Central	156	628	643	2.4	3.4
West North Central	179	687	708	3.0	3.4

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

[FY 2001 Payments compared to FY 2002 payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All charges	Portion attributable to federal rate change
West South Central	319	659	668	1.4	3.3
Mountain	126	681	690	1.3	3.4
Pacific	423	783	808	3.3	3.4
Puerto Rico	46	290	299	3.1	3.1
Rural by Region	2,079	433	442	2.0	3.4
New England	50	519	530	2.1	3.4
Middle Atlantic	74	453	467	3.1	3.4
South Atlantic	269	449	455	1.2	3.3
East North Central	276	441	452	2.4	3.4
East South Central	260	403	412	2.2	3.4
West North Central	479	421	430	2.3	3.4
West South Central	327	388	393	1.4	3.3
Mountain	195	458	461	0.7	3.2
Pacific	144	513	528	3.0	3.4
By Payment Classification:					
All hospitals	4,707	640	657	2.6	3.4
Large urban areas (populations over 1 million)	1,589	735	756	2.8	3.4
Other urban areas (populations of 1 million or fewer)	1,081	631	647	2.5	3.4
Rural areas	2,037	431	440	2.1	3.4
Teaching Status:					
Non-teaching	3,582	526	536	2.0	3.4
Fewer than 100 Residents	888	668	689	3.1	3.4
100 or more Residents	237	996	1,027	3.1	3.4
Urban DSH:					
100 or more beds	1,374	729	750	2.8	3.4
Less than 100 beds	309	483	486	0.5	3.2
Rural DSH:					
Sole Community (SCH/EACH)	545	395	395	0.1	3.2
Referral Center (RRC/EACH)	152	495	505	1.9	3.4
Other Rural:					
100 or more beds	70	407	418	2.6	3.3
Less than 100 beds	449	366	378	3.0	3.4
Urban teaching and no DSH:					
Both teaching and DSH	757	805	829	3.0	3.4
Teaching and no DSH	297	712	737	3.4	3.4
No teaching and DSH	926	583	596	2.2	3.3
No teaching and no DSH	690	577	587	1.7	3.4
Rural Hospital Types:					
Non special status hospitals	794	381	392	3.1	3.4
RRC/EACH	165	498	513	3.0	3.4
SCH/EACH	680	417	418	0.2	3.2
Medicare-dependent hospitals (MDH)	328	353	363	2.8	3.4
SCH, RRC and EACH	70	500	503	0.6	3.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY01 and FY02:					
Reclassified During Both FY01 and FY02	475	560	573	2.4	3.4
Reclassified During FY02 Only	152	558	573	2.7	3.4
Reclassified During FY01 Only	51	489	504	3.0	3.4
FY02 Reclassifications:					
All Reclassified Hospitals	627	559	573	2.5	3.4
All Nonclassified Hospitals	4,159	652	670	2.6	3.4
All Urban Reclassified Hospitals	117	742	765	3.1	3.4
Urban nonreclassified Hospitals	2,473	692	711	2.7	3.4
All Reclassified Rural Hospitals	510	486	496	2.1	3.4
Rural Nonreclassified Hospitals	1,566	384	391	1.8	3.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	439	452	3.0	3.4
Type of Ownership:					
Voluntary	2,327	654	672	2.8	3.4
Proprietary	627	632	637	0.9	3.3
Government	954	558	570	2.2	3.4
Medicare Utilization as a Percent of Inpatient Days:					
0–25	390	831	854	2.7	3.4
25–50	1,873	729	750	3.0	3.4
50–65	1,832	561	576	2.6	3.4
Over 65	585	514	516	0.3	3.3

Appendix B:

Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001 but ending in FY 2002. In FY 2003 and later, no payments will be made under the regular exceptions policy; hence, we will not compute a budget neutrality factor for regular exceptions in FY 2003 and later. As described in section V.D. of the preamble of this final rule, the budget neutrality adjustment for special exceptions will be based on historical costs. Consequently, there will be no need to estimate capital costs with the capital acquisition model. We will not publish this appendix after this final rule for the FY 2002 capital rates.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 8 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: the March 31, 2001 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), PPS–XIV (cost reporting periods beginning in FY 1997), PPS–XV (cost reporting periods beginning in FY 1998), and PPS–XVI (cost reporting periods beginning in FY 1999). In addition, to model payments, we use the April 1, 2001 update of the provider-specific file, and the March 1995 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 2001 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
No Match	1
Provider-Specific File Only	188
Provider-Specific and Audit File	4,606
Total	4,795

One hundred sixteen of the 4,795 hospitals had unusable or missing data, or had no cost reports available. For 50 of the 116 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 50 hospitals in the analysis. We were able to estimate hospital-specific amounts from the cost reports as shown in the following table.

Cost report	Number of hospitals
PPS–9	1
PPS–12	1
PPS–13	1
PPS–14	1
PPS–15	2
PPS–16	13
Total	19

Hence, we were able to use 69 (50 plus 19) of the 116 hospitals. The remaining 47 of the 116 hospitals could not be used in the analysis because we were not able to estimate their hospital-specific amount. An additional 41 hospitals could not be used in the analysis because we could not determine their capital costs, either because we had no cost reports for them or because there was insufficient cost report data. Accordingly, we used 4,707 hospitals for the analysis. Eighty-eight (47 plus 41) hospitals could not be used in the analysis because of insufficient (missing or unusable) information. These hospitals account for about 0.3 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random

numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 2000 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 2000 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 2000 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 2000 MedPAR file using the FY 2002 DRG relative weights included in section VI. of the Addendum to this final rule. The case-mix index is increased each year after FY 2000 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will decrease 0.9 percent in FY 2001. We project that case-mix will increase 1.0 percent in FY 2002. (Since we are using FY 2000 cases for our analysis, the FY 2000 increase in case-mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 2001, the budget neutrality adjustment factors were 0.99933 for the national rate and 1.00508 for the Puerto Rico rate. In determining these factors, we used the factors from the first half of FY 2001 (October 2000 through March 2001) published in the August 1, 2000 final rule since section 547 of Public Law 106–554 specifies that the special increases and adjustments in effect between April and October 2001 do not apply for discharges occurring after FY 2001 and should not be included in determining the payment rates in subsequent years.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

To determine the factors for FY 2002, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2002 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2001 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2001 relative weights and the FY 2002 geographic adjustment factor. In making the comparison, we held the FY 2002 Federal rate portion constant and set the other budget neutrality adjustment factor and the regular and special exceptions reduction factors to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99666 for FY 2002 to the previous cumulative FY 2001 adjustment of 0.99933, yielding a cumulative adjustment of 0.99599 through FY 2002. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.98991 for FY 2002 to the previous cumulative FY 2001 adjustment of 1.00508, yielding a cumulative adjustment of 0.99494 through FY 2002. We then compared estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2002 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights is 0.99668 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2002 are 0.99268 nationally and 0.99164 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS—Continued

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99846	1.00019	0.99865	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	[3]0.99771	[3]1.00009	[3]0.99780	0.99922	[3]1.00365	[3]1.00009	[3]1.00374	1.00508
2002	[4]0.99666	[4]0.99668	[4]0.99335	0.99268	[4]0.98991	[4]0.99668	[4]0.99662	0.99164

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. For FY 2002 additional payments for the ''regular'' exceptions are made only for cost reporting periods that begin before October 1, 2001. The adjustment for ''special'' exceptions payments (see § 412.348(g)) is described in section V.D. of the preamble of this final rule. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. In modeling exceptions for FY 2002, we calculated exceptions only for qualifying cost reporting periods. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. Since we will no longer use the model after this final rule for the FY 2002 rates, we will discontinue publishing this table after this final rule for the FY 2002 rates. The table below provides the actual factors for FYs 1992 through 2002, and the estimated factors that would be applicable through FY 2006. We caution that these are estimates for FYs 2003 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 0.99268 (0.99164 for Puerto Rico) for FY 2002 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2002.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor[1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction
1992	N/A	0.9813	0.9602		.9497		415.59
1993	6.07	.9756	.9162	.9980	.9496		417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2].9260	378.34
1995	3.44	.9734	.8432	.9998	.9414		376.83
1996	1.20	.9849	N/A	.9994	.9536	[3].9972	461.96
1997	0.70	.9358	N/A	.9987	.9481		438.92
1998	0.90	9659	N/A	.9989	.9382	[4].8222	371.51
1999	0.10	.9783	N/A	1.0028	.9392		378.10
2000	0.30	.9730	N/A	.9985	.9402		377.03
2001[5]	0.90	.9785	N/A	.9979	.9409		382.03
2002	1.30	[6].9929	N/A	0.9933	.9424		390.74
2003	0.70	.9975	N/A	[7]1.0000	[7].9424	[4]1.0255	405.39
2004	0.70	.9975	N/A	1.0000	.9424		408.23
2005	0.90	.9975	N/A	1.0000	.9424		411.90
2006	0.90	.9975	N/A	1.0000	.9424		415.61

[1] The incremental change over the previous year.
[2] OBRA 1993 adjustment.
[3] Adjustment for change in the transfer policy.
[4] Balanced Budget Act of 1997 adjustment.
[5] Rates are for the first half of FY 2001 (October 1, 2000 through March 31, 2001).
[6] Product of general exceptions factor (0.9941) and special exceptions factor (0.9988)

[7] Future adjustments are, for purposes of this projection, assumed to remain at the same level.

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

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2002 by hospitals subject to the prospective payment system and by hospitals or units excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XVII) of the Act, as amended by section 301 of Public Law 106–554, sets the FY 2002 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.55 percentage points for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2002 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 0.55 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2002 percentage increase in the rate-of-increase limits for hospitals and units excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available, or 0 percentage point if costs do not exceed two-thirds of the limit.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals and units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 2001 forecast of the FY 2002 market basket increase of 3.3 percent for hospitals subject to the prospective payment system, the update to the standardized amounts is 2.75 percent (that is, the market basket rate of increase minus 0.55 percentage points) for hospitals in both large urban and other areas. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent. The update for hospitals and units excluded from the prospective payment system can range from the percentage increase in the excluded hospital market basket (currently estimated at 3.3 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage point, resulting in an increase in the rate-of-increase limit between 0.8 and 3.3 percent, or 0 percent.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors 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. In its March 1, 2001 report, MedPAC stated that the legislated update of market basket minus 0.55 percentage points would provide a reasonable level of payments to hospitals. MedPAC did not make a separate recommendation for the hospital-specific rate applicable to SCHs and MDHs.

Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, we published the FY 2002 update factors recommended by the Secretary as Appendix D of the May 4, 2001 proposed rule (66 FR 22888). In that appendix, we discussed the recommendations of appropriate update factors, the analysis underlying our recommendations, and our response to MedPAC's recommendations concerning the update factors.

I. 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 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 reimbursement to health care providers.

We received several comments concerning our proposed recommendation.

Comment: One commenter questioned the reason for the difference between the 3.05 percent update to the standardized amounts recommended by the Secretary to the Congress as printed in the May 4, 2001 proposed rule (65 FR 22885) and the 2.55 percent proposed update used to establish the rates printed in the May 4, 2001 proposed rule (65 FR 22738).

Response: The President's FY 2002 budget estimated that the market basket for FY 2002 would be 3.6 percent. This estimate is prepared by the Office of Management and Budget (OMB) by applying future assumptions of economy-wide wage and consumer price index growth to the historical relationship between these factors and the market basket.

The market basket we have historically used to actually update the standardized amounts is estimated by our Office of the Actuary, in conjunction with Global Insights, Inc., DRI-WEFA. Although this estimate is generally very close to the OMB estimate, there are often some discrepancies due to the timing of the estimate and the differing future assumptions of the input factors.

Our final recommendation of the market basket percentage increase minus 0.55 percentage points for the update for hospitals subject to the prospective payment system, which is consistent with current law, did not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 3.3 for prospective payment hospitals (up from 3.1 estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update to the prospective payment system standardized amounts for both large urban and other urban areas is 2.75 percent (or consistent with current law, market basket percentage increase minus 0.55 percent). The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent (or consistent with current law, market basket percentage increase minus 0.55 percentage points).

Comment: Several commenters addressed the recent increases in the price of blood products. One commenter stated the increases represent up to one percent of annual DRG payments for hospitals that perform a significant number of surgeries. The commenters urged us to ensure that the DRG payments reflect price increases associated with rising blood prices.

Response: Section 301(c) of Public Law 106–554 requires the Secretary to consider the price of blood and blood products in the market basket index when the market basket is next rebased and revised and to determine whether those prices are adequately reflected.

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

We received no comments concerning our proposed recommendation. Our final recommendation for excluded hospitals and units did not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 3.3 for excluded hospitals and units (up from 3.0 estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update for hospitals and units excluded from the prospective payment system can range from market basket increase of 3.3 percent minus a percentage between 0 and 2.5 percent, or 0 percent depending on the relationship between the hospital's or unit's costs and its rate-of-increase limit, which results in an increase in the rate-of-increase limit between 0.8 and 3.3 percent, or 0 percent for FY 2002.

[FR Doc. 01–18868 Filed 7–31–01; 8:45 am]

BILLING CODE 4120–01–P