DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 482, 485, and 489

[CMS–1203–P]

RIN 0938–AL23

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare acute care hospital inpatient prospective payment systems for operating and capital costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 2002. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment systems.

In addition, we are proposing changes to other hospital payment policies, which include policies governing: payments to hospitals for the direct and indirect costs of graduate medical education; pass-through payments for the services of nonphysician anesthetists in some rural hospitals; clinical requirements for swing-bed services in critical access hospitals (CAHs); payments to provider-based entities; and implementation of the Emergency Medical Treatment and Active Labor Act (EMTALA).

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 8, 2002.

ADDRESSES: Mail written comments (an original and three copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1203–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

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

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

(Because access to the interior of the Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters who wish to retain proof of filing by stamping in and keeping an extra copy of the comments being filed.)

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

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

Centers for Medicare & Medicaid Services, Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke, CMS–1203–P; and

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

FOR FURTHER INFORMATION CONTACT: Stephen Phillips, (410) 786–4548, Operating Prospective Payments, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology, Hospital Geographic Reclassifications, and Postacute Transfer Issues. Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Provider-Based Entities, Critical Access Hospital (CAH), EMTALA Issues. Stephen Heffler, (410) 786–1211, Hospital Market Basket Rebasing. Jeannie Miller, (410) 786–3164, Clinical Standards for CAHs. Tom Hutchinson, (410) 786–8953, Hospital Communication with Medicare+Choice Organizations.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments

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

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I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System

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).

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

If the hospital is recognized as serving a disproportionate share of low-income patients, it receives a percentage add-on payment for each case paid through the acute care hospital inpatient prospective payment system. This percentage varies, depending on several factors which include the percentage of low-income patients served. It is applied to the DRG-adjusted base payment rate, plus any outlier payments received.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid through the acute care hospital inpatient prospective payment system. This percentage varies, depending on the ratio of residents to beds.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate.

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

The existing regulations governing payments to hospitals under the acute care hospital inpatient prospective payment system are located in 42 CFR part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the acute care hospital inpatient prospective payment system. These hospitals and units are: psychiatric hospitals and units; rehabilitation hospitals and units; long-term care hospitals; children's hospitals; and cancer hospitals. Various sections of the Balanced Budget Act of 1997 (Public Law 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Public Law 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554) provide for the implementation of prospective payment systems for rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals, as discussed below. Children's hospitals and cancer hospitals will continue to be paid on a cost-based reimbursement basis.

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

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units are being transitioned from a blend of reasonable cost-based reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and Federal prospective payments for cost reporting periods beginning January 1, 2002 through September 30, 2002, to payment on a fully Federal prospective rate effective for cost reporting periods beginning on or after October 1, 2002 (66 FR 41316, August 7, 2001). The statute also provides that IRFs may elect to receive the full prospective payment instead of a blended payment. The existing regulations governing payment under the inpatient rehabilitation facility prospective payment system (for rehabilitation hospitals and units) are located in 42 CFR part 412, subpart P.

Under the broad authority conferred to the Secretary by section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554, we are proposing to transition long-term care hospitals from payments based on reasonable cost-based reimbursement under section 1886(b) of the Act to fully Federal prospective rates during a 5-year period. For cost reporting periods beginning on or after October 1, 2006, we are proposing to pay long-term care hospitals under the fully Federal prospective payment rate. (See the proposed rule issued in the **Federal Register** on March 22, 2002 (67 FR 13416).) Under the proposed rule, long-term care hospitals would also be permitted to elect to be paid based on full Federal prospective rates. The proposed regulations governing payments under the long-term care hospital prospective payment system would be located in 42 CFR part 412, subpart O.

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 furnished by 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.

3. Critical Access Hospitals

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

4. Payments for Graduate Medical Education

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the

amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The existing regulations governing GME payments are located in 42 CFR part 413.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for operating costs and for capital-related costs in FY 2003. We also are proposing changes relating to payments for GME costs; payments to excluded hospitals and units; policies implementing EMTALA; clinical requirements for swing beds in CAHs; and other hospital payment policy changes. The proposed changes would be effective for discharges occurring on or after October 1, 2002.

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

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

As required by section 1886(d)(4)(C) of the Act, we adjust the DRG classifications and relative weights annually. Based on analyses of Medicare claims data, we are proposing to establish a number of new DRGs and to make changes to the designation of diagnosis and procedure codes under other existing DRGs. Our proposed changes for FY 2003 are set forth in section II. of this preamble.

Among the proposed changes discussed are:

- Revisions of DRG 1 (Craniotomy Age >17 Except for Trauma) and DRG 2 (Craniotomy for Trauma Age >17) to reflect the current assignment of cases involving head trauma patients with other significant injuries to MDC 24;
- Reconfiguration of DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack) and DRG 15 (Transient Ischemic Attack and Precerebral Occlusions) and creation of a new DRG 524 (Transient Ischemia);
- Creation of a new DRG for heart assist devices;
- Reassignment of the diagnosis code for rheumatic heart failure with cardiac catheterization;
- Assignment of new, and reassignment of existing, cystic fibrosis principal diagnosis codes;
- Designation of a code for insertion of totally implantable vascular access device (VAD);
- Changes in the DRG assignment for the bladder reconstruction procedure code.
- Changes in DRG and MDC assignments for numerous newborn and neonate diagnosis codes; and
- Changes in DRG assignment for cases of tracheostomy and continuous mechanical ventilation greater than 96 hours.

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

2. Proposed Changes to the Hospital Wage Index

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

- The FY 2003 wage index update, using FY 1999 wage data.
- Exclusion from the wage index of Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Collection of data for contracted administrative and general, housekeeping, and dietary services.
- Revisions to the wage index based on hospital redesignations and reclassifications by the Medicare Geographic Classification Review Board (MGCRB).
- Requests for wage data corrections, including clarification of our policies on mid-year corrections.

3. Revision and Rebasing of the Hospital Market Basket

In section IV. of this preamble, we discuss issues relating to our proposed rebasing and revision of the hospital market basket in developing the recommended FY 2003 update factor for the operating prospective payment rates and the excluded hospital rate-of-increase limits. We also set forth the data sources used to determine the proposed revised market basket relative weights and choice of price proxies.

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

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

- Options for expanding the postacute care transfer policy.
- Refinement of the application of a hospital bed-count policy that would more accurately reflect the size of a hospital's operations.
- Clarification of the application of the statutory provisions on the calculation of hospital-specific rates for SCHs.
- Technical change regarding additional payments for outlier cases.
- Rural referral centers proposed case-mix index values for FY 2003.
- Changes relating to the IME adjustment, including resident-to-bed ratio caps and counting beds for IME and DSH adjustments.
- Clarification and codification of classification requirements for MDHs and intermediary evaluations of cost reports for these hospitals.
- Changes to policies on pass-through payments for the costs of nonphysician anesthetists in some rural hospitals.
- Clarification of policies relating to implementing 3-year reclassifications of hospitals and other policies related to hospital reclassifications decisions made by the MGCRB.
- Changes relating to payment for the direct costs of GME.
- Changes related to emergency medical conditions in hospital emergency department under the EMTALA provisions.
- Criteria for and payments to provider-based entities.
- CMS-directed reopening of intermediary determinations and hearing decisions on provider reimbursements.

5. Prospective Payment System for Capital-Related Costs

In section VI. of this preamble, we specify the proposed payment requirements for capital-related costs which include:

- Capital-related costs for new hospitals.
- Additional payments for extraordinary circumstances.
- Restoration of the 2.1 percent reduction to the standard Federal capital prospective payment system rate.
- Clarification of the special exceptions payment policy.

6. Proposed Changes for Hospitals and Hospital Units Excluded From the Prospective Payment Systems

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

- Payments for existing excluded hospitals and hospital units for FY 2003.
- Updated caps for new excluded hospitals and hospital units.
- Revision of criteria for exclusion of satellite facilities from the acute care hospital inpatient prospective payment system.

• The prospective payment systems for inpatient rehabilitation hospitals and units and long-term care hospitals.

• Changes in the advance notification period for CAHs electing the optional payment methodology.

• Removal of the requirement on CAHs to use a State resident assessment instrument (RAI) for patient assessments for swing-bed patients.

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

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2003 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2003 for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system.

8. Impact Analysis

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

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

Section 1886(e)(3) of the Act requires the Secretary to report to Congress on our initial estimate of a recommended update factor for FY 2003 for payments to hospitals included in the acute care hospital inpatient prospective payment system, and hospitals excluded from this prospective payment system. This report is included as Appendix B to this proposed rule.

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

As required by sections 1886(e)(4) and (e)(5) of the Act, appendix C provides our recommendation of the appropriate percentage change for FY 2003 for the following:

• Large urban area and other area average standardized amounts (and hospital-specific rates applicable to SCHs and MDHs) for hospital inpatient services paid under the 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 acute care hospital inpatient prospective payment system.

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In section VIII. of this preamble, we discuss the MedPAC recommendations and any actions we are proposing to take with regard to them (when an action is recommended). For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220 or visit MedPAC's website at: *www.medpac.gov.*

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Under the acute care hospital inpatient 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. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2002 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the acute care hospital inpatient 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).

For FY 2002, cases are assigned to one of 506 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. 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 patients' principal diagnosis before assignment to a DRG. However, for FY 2002, there are eight DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These are the DRGs for heart, liver, bone marrow, lung transplants, simultaneous pancreas/kidney, and pancreas transplants (DRGs 103, 480, 481, 495, 512, and 513, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

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

Generally, nonsurgical procedures and minor surgical procedures not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Patients' diagnosis, procedure, discharge status, and demographic information is fed into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate

DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and, for a limited number of DRGs, demographic information (that is, sex, age, and discharge status). The GROUPER is used both to classify current cases for purposes of determining payment and to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for the use of particular data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by mid-October, so that we can test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with next year's proposed rule.

The major changes we are proposing to the DRG classification system for FY 2003 GROUPER version 20.0 and to the methodology to recalibrate the DRG weights are set forth below. Unless otherwise noted, our DRG analysis is based on data from 100 percent of the FY 2001 MedPAR file, which contains hospital bills received through May 31, 2001, for discharges in FY 2001.

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

a. Proposed Revisions of DRGs 1 and 2

Currently, adult craniotomy patients are assigned to either DRG 1 (Craniotomy Age >17 Except for Trauma) or DRG 2 (Craniotomy for Trauma Age >17). The trauma distinction recognizes that head trauma patients requiring a craniotomy often have multiple injuries affecting other body parts. However, we note that the structure of these DRGs predates the creation in FY 1991 of MDC 24 (Multiple Significant Trauma). The creation of MDC 24 resulted in head trauma patients with other significant injuries being assigned to MDC 24 and removed from DRG 2. In FY 1990, there was a 16-percent difference in the DRG weights for DRG l and DRG 2. In FY 1992, after the creation of MDC 24, the percentage difference in the DRG weights for DRG 1 and DRG 2 had declined to 1.2 percent. The FY 2002 payment weight for DRG 1 is 3.2713 and for DRG 2 is 3.3874, a 3.5 percent difference.

For FY 2003, we reevaluated the GROUPER logic for DRGs 1 and 2 by combining the patients assigned to these DRGs and examining the impact of other patient attributes on patient charges. The presence or absence of a CC was found to have a substantial impact on patient charges.

Cases in DRGs 1 and 2	Number of patients	Average charges
With CC	19,012	$49,659
Without CC	9,618	26,824

Thus, there is an 85.1 percent difference in average charges for the groups with and without CC for the combined DRGs 1 and 2. On this basis, we are proposing to redefine and retitle DRGs 1 and 2 as follows: DRG 1 (Craniotomy Age >17 with CC); and DRG 2 (Craniotomy Age >17 without CC).

b. Proposed Revisions of DRGs 14 and 15

To assess the appropriate classification of patients with stroke symptoms, we evaluated the assignment of cases to DRGs 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack (TIA) and DRG 15 (Transient Ischemic Attack and Precerebral Occlusions). Our data review indicated that the cases in DRGs 14 and 15 fell into three discrete groups. The first group included cases in which the patients were very sick, with severe intracranial lesions or subarachnoid hemorrhage and severe consequences. The second group included cases in which patients had not suffered a debilitating stroke but instead may have experienced a transient ischemic attack. The patients in the second group had one half of the average length of stay in the hospital as the first group. The third group of cases included patients who appeared to suffer strokes with minor consequences, as well as those having occluded vessels without having a full-blown stroke.

We found that patients who have intracranial hemorrhage and patients who have infarction are similar in severity. These cases are more frequent in occurrence than cases with patients who have subarachnoid hemorrhage. Therefore, we are proposing to continue to group patients with intracranial hemorrhage and infarction together. These types of cases are different from patients with, for example, an occlusive carotid artery without infarction. In this common group of cases, patients are not as severely ill because they typically have lesser degrees of functional status deficits.

Our analysis indicates that we can improve the clinical and resource cohesiveness of DRGs 14 and 15 by reassigning several specific ICD–9–CM codes. For example, code 436 (Acute, but ill-defined, cerebrovascular disease) is not a specific code and contains patients with a wide range of deficits and anatomic problems. Our data show that these cases consume fewer resources and have shorter lengths of stay than other cases in DRG 14. Therefore, we are proposing to remove code 436 from DRG 14 and reassign it to DRG 15. We also are proposing to create a third new DRG to further identify these cases. The proposed revised or new DRG titles are as follows: DRG 14 (Intracranial Hemorrhage and Stroke with Infarction); DRG 15 (Nonspecific Cerebrovascular and Precerebral Occlusion without Infarction); and DRG 524 (Transient Ischemia).

The following table represents a proposed reconfiguration of DRGs 14 and 15 and the creation of a new DRG 524 reflecting these three categorizations:

Proposed DRG and title	Number of cases	Average length of stay (days)	Average charge
Revised DRG 14 (Intracranial Hemorrhage and Stroke with Infarction)	164,786	6.1	$15,643
Revised DRG 15 (Nonspecific Cerebrovascular and Precerebral Occlusion without Infarction)	70,866	4.9	11,595
New DRG 524 (Transient Ischemia)	92,835	3.3	8,633

The proposed reconfiguration of DRGs 14 and 15 would result in the following codes being designated as principal diagnosis codes in proposed revised DRG 14:

- 430, Subarachnoid hemorrhage
- 431, Intracerebral hemorrhage
- 432.0, Nontraumatic extradural hemorrhage
- 432.1, Subdural hemorrhage
- 432.9, Unspecified intracranial hemorrhage
- 433.01, Occlusion and stenosis of basilar artery, with cerebral infarction
- 433.11, Occlusion and stenosis of carotid artery, with cerebral infarction
- 433.21, Occlusion and stenosis of vertebral artery, with cerebral infarction
- 433.31, Occlusion and stenosis of multiple and bilateral arteries, with cerebral infarction
- 433.81, Occlusion and stenosis of other specified precerebral artery, with cerebral infarction
- 433.91, Occlusion and stenosis of unspecified precerebral artery, with cerebral infarction
- 434.01, Cerebral thrombosis with cerebral infarction
- 434.11, Cerebral embolism with cerebral infarction
- 434.91, Cerebral artery occlusion, unspecified, with cerebral infarction

In addition, we are proposing that the following two codes be moved from DRG 14 to DRG 34 (Other Disorders of Nervous System with CC) and DRG 35 (Other Disorders of Nervous System without CC): Code 437.3 (Cerebral aneurysm, nonruptured) and Code 784.3 (Aphasia). These codes do not represent acute conditions. Aphasia, for example, could result from a cerebral infarction, but if it does, the infarction should be correctly coded as the principal diagnosis.

The proposed redefined DRG 15 would contain the following principal diagnosis codes:

- 433.00, Occlusion and stenosis of basilar artery, without mention of cerebral infarction
- 433.10, Occlusion and stenosis of carotid artery, without mention of cerebral infarction
- 433.20, Occlusion and stenosis of vertebral artery, without mention of cerebral infarction
- 433.30, Occlusion and stenosis of multiple and bilateral arteries, without mention of cerebral infarction
- 433.80, Occlusion and stenosis of other specified precerebral artery, without mention of cerebral infarction
- 433.90, Occlusion and stenosis of unspecified precerebral artery, without mention of cerebral infarction
- 434.00, Cerebral thrombosis without mention of cerebral infarction
- 434.10, Cerebral embolism without mention of cerebral infarction
- 434.90, Cerebral artery occlusion, unspecified, without mention of cerebral infarction
- 436, Acute, but ill-defined, cerebrovascular disease

In addition, we are proposing to remove the following codes from the existing DRG 15 and place them in the proposed newly created DRG 524:

- 435.0, Basilar artery syndrome
- 435.1, Vertebral artery syndrome
- 435.2, Subclavian steal syndrome
- 435.3, Vertebrobasilar artery syndrome
- 435.8, Other specified transient cerebral ischemias
- 435.9, Unspecified transient cerebral ischemia

We are proposing to move code 437.1 (Other generalized ischemic cerebrovascular disease) from DRG 16 (Nonspecific Cerebrovascular Disorders with CC) and DRG 17 (Nonspecific Cerebrovascular Disorders without CC) and add it to the proposed new DRG 524. This proposed change represents a modification to improve clinical coherence and seems to be a logical change for the construction of the proposed new DRG 524.

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

a. Heart Assist Systems

Heart failure is typically caused by persistent high blood pressure (hypertension), heart attack, valve disease, other forms of heart disease, or birth defects. It is a chronic condition in which the lower chambers of the heart (ventricles) cannot pump sufficient amounts of blood to the body. This causes the organs of the body to progressively fail, resulting in numerous medical complications and frequently death. DRG 127 (Heart Failure and Shock), to which heart failure cases are assigned, is the single most common DRG in the Medicare population, and represents the medical, not surgical, treatment options for this group of patients.

In many cases, heart transplantation would be the treatment of choice. However, the low number of donor hearts limits this treatment option. Circulatory support devices, also known as heart assist systems or left ventricular assist devices (LVADs), offer a surgical alternative for end-stage heart failure patients. This type of device is often implanted near a patient's native heart and assumes the pumping function of the weakened heart's left ventricle. Studies are currently underway to evaluate LVADs as permanent support for end-stage heart failure patients.

We have reviewed the payment and DRG assignment of this type of device in the past. Originally, these cases were assigned to DRG 110 (Major Cardiovascular Procedures with CC) and DRG 111 (Major Cardiovascular Procedures without CC) in the September 1, 1994 final rule (59 FR 45345). A more specific procedure code, 37.66 (Implant of an implantable, pulsatile heart assist system) was made effective for use with hospital discharges occurring on or after October 1, 1995. In the August 29, 1997 final rule (62 FR 45973), we reassigned these cases to DRG 108 (Other Cardiothoracic Procedures), because it was the most clinically similar DRG with the best match in resource consumption according to our data. In the July 31, 1998 final rule (63 FR 40956), we again reviewed our data and discovered that the charges for implantation of an LVAD were increasing at a greater rate than the average charges for DRG 108. The length of stay for cases with code 37.66 was approximately 32 days, or three times as long as all other DRG 108 cases. Therefore, we decided to move LVAD cases from DRG 108 to DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization). We continued to review our data and discuss this topic in the FY 1999 and FY 2000 annual final rules: July 30, 1999 (64 FR 41498) and August 1, 2000 (65 FR 47058).

In the August 1, 2001 final rule (66 FR 39838), we remodeled MDC 5 to add five new DRGs. We also added procedure codes 37.62 (Implant of other heart assist system), 37.63 (Replacement and repair of heart assist system), and 37.65 (Implant of an external, pulsatile heart assist system) to DRGs 104 and 105. We removed defibrillator cases from DRGs 104 and 105 and assigned them to DRG 514 (Cardiac Defibrillator Implant with Cardiac Catheterization) and DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization) to make these DRGs more clinically coherent. This also increased the relative weights for DRGs 104 and 105, as the defibrillator cases had lower average charges than other cases in those two DRGs.

In the FY 2001 MedPAR data file, we found 185 LVAD cases in DRG 104 and 90 cases in DRG 105, for a total of 275 cases. These cases represent 1.3 percent of the total cases in DRG 104, and approximately 0.5 percent of the total

cases in DRG 105. However, the average charges for these cases are approximately $36,000 and $85,000 higher than the average charges for cases in DRGs 104 and 105, respectively.

This situation presents a dilemma, in that the technology has been available since 1995 and is gradually increasing in utilization, while LVAD cases involving the technology remain a small part of the total cases in these two DRGs. In fact, removing LVAD cases from the calculation of the average charge changes the average by only -0.4 percent and -0.5 percent for DRGs 104 and 105, respectively. Therefore, despite the dramatically higher average charges for LVADs compared to the DRG averages, the relative volume is insufficient to affect the average to any great degree.

Therefore, we are proposing to create a new DRG 525 (Heart Assist System Implant), which would contain these cases. The proposed FY 2003 relative weight for proposed new DRG 525 is 11.3787.

The new DRG would consist of any principal diagnosis in MDC 5, plus one of the following surgical procedures:

- 37.62, Implant of other heart assist system
- 37.63, Replacement and repair of heart assist system
- 37.65, Implant of an external, pulsatile heart assist system
- 37.66, Implant of an implantable, pulsatile heart assist system

Cases in which a subsequent heart transplant occurs during the hospitalization episode would continue to be assigned to DRG 103 (Heart Transplant) because cases involving procedure codes 336 (Combined heart/lung transplant) and 375 (Heart transplant) are assigned to DRG 103, regardless of other codes included on the bill.

We reiterate a discussion we included in the August 1, 2000 final rule (65 FR 47058) regarding placement of code 37.66 in the MCE screening software as a noncovered procedure. The default designation for that code will continue to be ''noncovered'' because of the stringent conditions that must be met by hospitals in order to receive payment for implantation of the device.

Section 65–15 of the Medicare Coverage Issues Manual (Artificial Hearts and Relative Devices) provides the national coverage determination regarding Medicare coverage of these devices. This section may be accessed online at *www.hcfa.gov/pubforms/06_cim/ci00.htm.*

b. Moving Diagnosis Code 398.91 (Rheumatic Heart Failure) From DRG 125 to DRG 124

DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction (AMI), with Cardiac Catheterization and Complex Diagnosis) and DRG 125 (Circulatory Disorders Except Acute Myocardial Infarction (AMI) with Cardiac Catheterization without Complex Diagnosis) have a somewhat complex DRG logic. In order to be assigned to DRG 124 or 125, the patient must first have a circulatory disorder, which would be one of the diagnoses included in MDC 5. However, these DRGs exclude acute myocardial infarctions. Therefore, these DRGs are comprised of cases with a diagnosis from MDC 5, excluding acute myocardial infarction, but also with a cardiac catheterization during the stay.

DRGs 124 and 125 are then further defined by whether or not the patient had a complex diagnosis. If the patient had a complex diagnosis, the case is assigned to DRG 124. If the patient does not have a complex diagnosis, the case is assigned to DRG 125. A list of diagnoses that comprise complex diagnoses is identified within DRG 124. These diagnoses can be listed as either a principal or secondary diagnosis.

We have received correspondence regarding the current assignment of diagnosis code 398.91 (Rheumatic heart failure). The correspondent pointed out that, while other forms of heart failure are listed as complex diagnoses under DRG 124, rheumatic heart failure is not included as a complex diagnosis within that DRG. Currently, if a patient with rheumatic heart failure receives a cardiac catheterization, the case is assigned to DRG 125.

The correspondent had conducted a study and found that patients with rheumatic heart failure who receive a cardiac catheterization have lengths of stay that are significantly longer than patients with other forms of heart failure who receive a cardiac catheterization and who are assigned to DRG 125. The correspondent found that these patients have lengths of stay more similar to those cases assigned to DRG 124 (which have other forms of heart failure), and recommended that diagnosis code 398.91 be added to the list of complex diagnoses within DRG 124.

Within our claims data, we found 439 cases of patients in DRG 125 with rheumatic heart failure who received a cardiac catheterization. The average charges for these rheumatic heart failure cases were almost twice as much as for other cardiac patients in DRG 125 who received a cardiac catheterization and who did not have a diagnosis of rheumatic heart failure. We also conferred with our medical consultants and they agree that rheumatic heart failure with cardiac catheterization is a complex diagnosis and should be assigned to DRG 124 along with the other complex forms of heart failure cases involving cardiac catheterization.

We are proposing to add code 398.91 to DRG 124 as a complex diagnosis. As a result, catheterization cases with rheumatic heart disease would no longer be assigned to DRG 125.

c. Radioactive Element Implant

In the August 1, 2001 final rule, we created DRG 517 (Percutaneous Cardiovascular Procedure without Acute Myocardial Infarction (AMI) with Coronary Artery Stent Implant) as a result of the overall DRG splits based on the presence of AMI (66 FR 39839). We assigned code 92.27 (Implantation or insertion of radioactive elements) to DRG 517 because we believed that code 92.27 would always accompany cases involving a percutaneous cardiovascular procedure and intravascular radiation treatment. We have since determined that code 92.27 can also be present as a stand-alone code in other types of cases. When cases with code 92.27 do not meet the criteria for DRG 517, they are currently directed into DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). Because DRG 468 is for cases in which the O.R. procedure is unrelated to the principal diagnosis, rather than assign cases with code 92.27 that would otherwise be assigned to MDC 5 to DRG 468 because they do not meet the criteria for assignment to DRG 517, we are proposing to assign these cases to DRG 120 (Other Circulatory System O.R. Procedures).

4. MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders)

Currently, when ICD–9–CM code 277.00 (Cystic Fibrosis without mention of meconium ileus) is reported as the principal diagnosis, it is assigned to the following DRG series in MDC 10: DRG 296 (Nutritional and Metabolic Disease, Age >17 with CC); DRG 297 (Nutritional and Metabolic Disease, Age >17 without CC); and DRG 298 (Nutritional and Metabolic Disease, Age 0–17).

As part of our annual review of DRG assignments and based on correspondence that we have received, we examined claims relating to cases involving code 277.00 as a principal diagnosis in DRGs 296, 297, and 298. Our analysis of the average charges for cases in which code 277.00 was the principal diagnosis in DRGs 296, 297, and 298 indicates that resource

utilization for these cases is quite different from resource utilization for other cases in the three DRGs. We believe that this difference in resource utilization is due to the fact it is not uncommon for cystic fibrosis patients to be admitted with pulmonary complications. Our findings on the number of cases and the average charges in the three DRGs when code 277.00 is assigned as the principal diagnosis, and our findings for all cases in the three DRGs, are indicated in the charts below.

CASES IN DRG 296, 297, AND 298 WITH CODE 277.00 AS THE PRINCIPAL DIAGNOSIS

DRG and description	Number of cases	Average charges
DRG 296 (Nutritional & Metabolic Disease Age >17 with CC)	271	$34,111
DRG 297 (Nutritional & Metabolic Disease Age >17 with CC)	133	21,998
DRG 298 (Nutritional & Metabolic Disease Age 0–17)	0	.....

ALL CASES IN DRG 296, 297, 298

DRG and description	Number of cases	Average charges
DRG 296 (Nutritional & Metabolic Disease Age >17 with CC)	169,768	$10,480
DRG 297 (Nutritional & Metabolic Disease Age >17 without CC)	31,560	6,190
DRG 298 (Nutritional & Metabolic Disease Age 0–17)	17	8,603

Based on the results of our analysis, we are proposing that three new cystic fibrosis principal diagnosis codes be assigned to specific DRGs and MDCs, and that other changes be made to DRG and MDC assignments of existing cystic fibrosis codes, as discussed below.

We are proposing to create the following three new principal diagnosis codes:

- 277.02 (Cystic fibrosis with pulmonary manifestations)
- 277.03 (Cystic fibrosis with gastrointestinal manifestations)
- 277.09 (Cystic fibrosis with other manifestations)

We are proposing that existing code 277.01 (Cystic fibrosis with mention of meconium ileus) would continue to be assigned to DRG 387 (Prematurity with Major Problems) and DRG 389 (Full Term Neonate with Major Problems) in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period), since it is a newborn diagnosis code.

Because proposed new code 277.02 would identify those patients with cystic fibrosis who have pulmonary manifestations, we are proposing to assign cases in which the principal diagnosis is the proposed new code 277.02 to DRG 79 (Respiratory Infection and Inflammations Age >17 with CC), DRG 80 (Respiratory Infections and Inflammations Age >17 without CC), or DRG 81 (Respiratory Infections and Inflammations Age 0–17) in MDC 4 (Diseases and Disorders of the Respiratory System).

We are proposing that proposed new code 277.03 would be assigned to DRG 188 (Other Digestive System Diagnoses Age >17 with CC), DRG 189 (Other Digestive System Diagnoses Age >17 without CC), and DRG 190 (Other Digestive System Diagnoses Age 0–17) in MDC 6 (Diseases and Disorders of the Digestive System), because of its specific relationship to the digestive system.

Since proposed new code 277.09 could involve a number of manifestations (excluding pulmonary and gastrointestinal), we are proposing to assign this proposed new code to DRGs 296, 297, and 298 in MDC 10, where we are retaining the current assignment of existing code 277.00.

The following chart summarizes our proposed DRG and MDC assignments for new and existing cystic fibrosis principal diagnosis codes:

Principal diagnosis code and description	Proposed MDC assignment	Proposed DRG assignments
Existing 277.00 (Cystic fibrosis without mention of meconium ileus)	10	296, 297, 298
Existing 277.01 (Cystic fibrosis with mention of meconium ileus)	15	387, 389
Proposed new 277.02 (Cystic fibrosis with pulmonary manifestations)	4	79, 80, 81
Proposed new 277.03 (Cystic fibrosis with gastrointestinal manifestations)	6	188, 189, 190
Proposed new 277.09 (Cystic fibrosis with other manifestations)	10	296, 297, 298

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

a. Insertion of Totally Implantable Vascular Access Device (VAD)

In the August 1, 2001 final rule (66 FR 39844), we discussed our review of the DRG assignment of code 86.07 (Insertion of totally implantable vascular access device (VAD)). Code 86.07 is considered a nonoperative procedure when it occurs in MDC 11. Therefore, patients in renal (kidney) failure requiring implantation of this device for dialysis are grouped to medical DRG 316 (Renal Failure). We examined whether implantation of this device should be removed from DRG 316 and placed into surgical DRG 315 (Other Kidney and Urinary Tract O.R. Procedures).

Implantation of a VAD into the chest wall and blood vessels of a patient's upper body allows access to a patient's vessels via an implanted valve and cannula. Two devices are implanted during one operative session. One system is implanted arterially (the ''draw''), while the other is implanted venously (the ''return''). Typically, the VAD allows access to the patient's blood for hemodialysis purposes when other sites in the body have been exhausted. The device is usually inserted in the outpatient setting. Operative time is approximately 1 to 1.5 hours.

In the FY 2002 final rule (66 FR 39844–39845), we pointed out that cases where the VAD was inserted as an inpatient procedure also involved other complications, leading to higher average charges. Therefore, we indicated that we were not assigning code 86.07 to DRG 315 at that time, but we would consider other alternative adjustments to DRGs 315 and 316.

For FY 2003, we explored whether DRG 315 should be split based on existence or nonexistence of CCs. However, during our consideration of this alternative, we discovered that DRG 315 does not lend itself to a CC split due to the high occurrence of cases in this DRG that already have complications identified on the CC list. Therefore, we reexamined cases in DRGs 315 and 316 in the FY 2001 MedPAR file. The results are reflected in the chart below:

	With Code 86.07	Without Code 86.07
DRG 315 (surgical):		
Number of Cases	354	21,089.
Average Length of Stay.	12.6 days	6.7 days.
Average Charges ..	$47,251 ...	$25,622.
DRG 316 (Medical):		
Number of Cases	887	76,676.
Average Length of Stay.	10.3	6.6 days.
Average Charges ..	$31,904 ...	$16,934.

These results are similar to the findings included in the FY 2002 final rule that were based on data from the FY 2000 MedPAR file (66 FR 39845).

We found that the average length of stay in DRG 315 for patients not receiving the VAD is 6.7 days, while those patients who received the VAD had an average length of stay of 12.6 days. We found the average charges in DRG 315 for patients not receiving the VAD were approximately $25,622, while the average charges for those patients who received the VAD were $47,251.

We found that the cases receiving the VAD as an inpatient procedure are significantly more costly than other cases in DRG 316. Therefore, we are proposing to designate code 86.07 as an O.R. procedure under MDC 11. Specifically, code 86.07 would be recognized as an O.R. procedure code in MDC 11 and assigned to DRG 315 when combined with the following principal diagnosis codes from DRG 316:

- 403.01, Malignant hypertensive renal disease with renal failure
- 403.11, Benign hypertensive renal disease with renal failure
- 403.91, Unspecified hypertensive renal disease with renal failure
- 404.02, Malignant hypertensive heart and renal disease with renal failure
- 404.12, Malignant hypertensive heart and renal disease with renal failure
- 404.92, Unspecified hypertensive heart and renal disease with renal failure
- 584.5, Acute renal failure with lesion of tubular necrosis
- 584.6, Acute renal failure with lesion of renal cortical necrosis
- 584.7, Acute renal failure with lesion of renal medullary (papillary) necrosis
- 584.8, Acute renal failure with other specified pathological lesion in kidney
- 584.9, Acute renal failure, unspecified
- 585, Chronic renal failure
- 586, Renal failure, unspecified
- 788.5, Oliguria and anuria
- 958.5, Traumatic anuria

b. Bladder Reconstruction

We received correspondence regarding the current classification of procedure code 57.87 (Reconstruction of urinary bladder) as a minor bladder procedure and the assignment of the code under DRG 308 (Minor Bladder Procedures with CC) and DRG 309 (Minor Bladder Procedures without CC). The correspondent believed that bladder reconstruction is not a minor procedure, submitted individual hospital charges to support this contention, and recommended that the code be classified as a major procedure and assigned to a higher weighted DRG.

Our clinical advisors indicated that reconstruction of the bladder is a more extensive procedure than the other minor bladder procedures in DRGs 308 and 309. They agree that the bladder reconstruction procedure is as complex as the procedures under code 57.79 (Total cystectomy) and the other major bladder procedures in DRGs 303 through 305.

As indicated in the chart below, we found that the average charges for bladder reconstruction are significantly higher than the average charges for other minor procedures within DRGs 308 and 309:

	With Code 57.87	Without Code 57.87
DRG 308 (minor bladder procedure with CC):		
Number of Cases	64	5,066
Average Charges	$36,560	$19,923
DRG 309 (minor bladder procedures without CC):		
Number of Cases	25	3,021
Average Charges	$23,390	$11,200

We found that procedure code 57.87 may be more appropriately placed in DRG 303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm), 304 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm with CC), and DRG 305 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm without CC), based on average charges for procedures in these three DRGS as indicated in the following chart:

DRG	Number of cases	Average charges
303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm)	14,116	$30,691
304 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm with CC)	8,060	30,577
305 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm without CC)	2,029	15,492

Based on the results of our analysis and the advice of our medical consultants discussed above, we are proposing to classify code 57.87 as a major bladder procedure and to assign it to DRGs 303, 304, and 305.

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

The primary focus of updates to the Medicare DRG classification system is for changes relating to the Medicare patient population, not the pediatric or neonatal patient populations. However, the Medicare DRGs are sometimes used to classify other patient populations. Over the years, we have received comments about aspects of the Medicare newborn DRGs that appear problematic, and we have responded to these on an individual basis. Some correspondents have requested that we take a closer

overall look at the DRGs within MDC 15.

To respond to this request relating to review of MDC 15, we contacted the National Association of Children's Hospitals and Related Institutions (NACHRI), along with our own medical advisors, to obtain proposals for possible revisions of the existing DRG categories in MDC 15. The focus of the requested proposals was to refine category definitions within the framework of the existing seven broadly defined neonatal DRGs. The proposals also were to take advantage of the new, more specific neonatal diagnosis codes to be adopted, effective October 1, 2002, to assist with refinements to the existing DRG category definitions.

In preparing these proposed changes to MDC 15, we have considered comments and suggestions previously received, including suggestions from NACHRI on how to make improvements within the existing framework of seven very broadly defined neonatal DRGs. In the future, we may consider broader changes to MDC 15.

a. Definition of MDC 15

The existing diagnosis definitions for MDC 15 include certain diagnoses that may be present at the time of birth but may also continue beyond the perinatal period.

These diagnoses are basically congenital anomalies, and even though they may continue beyond the perinatal period, they are assigned to MDC 15 which is specific to newborns and neonates.

The diagnosis codes assigned to the DRGs under MDC 15 have been a source of confusion because older children and adults can be admitted with these principal diagnoses and assigned to newborn or neonate DRGs in MDC 15 as if they were newborns.

Our medical consultants and NACHRI have reviewed the listing of diagnosis codes and identified those that should not be routinely classified under MDC 15. As a result of this review, we are proposing that the following list of diagnosis codes be removed from MDC 15:

- 758.9, Conditions due to anomaly of unspecified chromosome
- 759.4, Conjoined twins
- 759.7, Multiple congenital anomalies, so described
- 759.81, Prader-Willi Syndrome
- 759.83, Fragile X Syndrome
- 759.89, Other specified anomalies
- 759.9, Congenital anomaly, unspecified
- 779.7, Periventricular leukomalacia
- 795.2, Nonspecific abnormal findings on chromosomal analysis

We are proposing to assign the nine diagnosis codes listed above to the following MDCs and DRGs (if medical):

Diagnosis code	Title	Proposed MDC assignment	Proposed DRG assignment
758.9	Conditions due to anomaly of unspecified chromosome.	23	467 (Other Factors Influencing Health Status).
759.4	Conjoined twins	6	188, 189, 190 (Other Digestive System Diagnoses, age >17 with CC, Age >17 without CC, and Age 0–17, respectively).
759.7	Multiple congenital anomalies, so described	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.81	Prader-Willi Syndrome	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.83	Fragile x Syndrome	19	429 (Organic Disturbances and Mental Retardation)
759.89	Other specified anomalies	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.9	Congenital anomaly, unspecified	23	467 (Other Factors Influencing Health Status).
779.7	Periventricular leukomalacia	1	34, 35 (Other Disorders of the Nervous System with CC and without CC, respectively).
795.2	Nonspecific abnormal findings on chromosomal analysis.	23	467 (Other Factors Influencing Health Status).

The following three specific 4-digit diagnosis codes have been determined invalid by the ICD–9–CM Coordination and Maintenance Committee, effective October 1, 2002, and we are proposing to remove them from MDC 15.

- 770.8, Other newborn respiratory problems
- 771.8, Other infection specific to the perinatal period
- 779.8, Other specified conditions originating in the perinatal period

The above three codes are being replaced by 5-digit codes to capture more detail. These new 5-digit codes are assigned to DRGs within MDC 15 and are listed among the codes in Table 6A—New Diagnosis Codes in the Addendum of this proposed rule.

In addition, the ICD–9–CM Coordination and Maintenance Committee created a number of new codes, effective October 1, 2002, to capture newborn and neonatal conditions. Therefore, we are proposing to add the following new 23 diagnosis codes to MDC 15:

- 747.83, Persistent fetal circulation
- 765.20, Unspecified weeks of gestation
- 765.21, Less than 24 completed weeks of gestation
- 765.22, 24 completed weeks of gestation
- 765.23, 25–26 completed weeks of gestation
- 765.24, 27–28 completed weeks of gestation
- 765.25, 29–30 completed weeks of gestation
- 765.26, 31–32 completed weeks of gestation
- 765.27, 33–34 completed weeks of gestation
- 765.28, 35–36 completed weeks of gestation
- 765.29, 37 or more completed weeks of gestation
- 770.81, Primary apnea of newborn
- 770.82, Other apnea of newborn
- 770.83, Cyanotic attacks of newborn
- 770.84, Respiratory failure of newborn
- 770.89, Other respiratory problems after birth
- 771.81, Septicemia [sepsis] of newborn
- 771.82, Urinary tract infection of newborn
- 771.83, Bacteremia of newborn
- 771.89, Other infections specific to the perinatal period
- 779.81, Neonatal bradycardia
- 779.82, Neonatal tachycardia
- 779.89, Other specified conditions originating in perinatal period

b. DRG 386 (Extreme Immaturity or Respiratory Distress Syndrome, Neonate)

The existing DRG 386 is defined by the presence of one of the ICD–9–CM extreme prematurity codes (765.01 through 765.05) with the fifth digit indicating birthweight less than 1,500 grams (3.3 pounds). NACHRI has identified two weaknesses in the use of the fifth digit to define prematurity.

One weakness relates to determining extreme immaturity, which, in part, is limited by the existing ICD–9–CM diagnosis codes. The existing ICD–9–CM definition for the extreme immaturity codes ''usually implies birthweight less than 1,000 grams (2.2 pounds) or gestational age less than 28 completed weeks,'' or both. The fifth digit provides range values for birthweight but gives no information on gestational age. A specific and distinct set of ICD–9–CM diagnosis codes for gestational age is to be introduced effective October 1, 2002. These new codes will provide a clearer basis for differentiating extreme immaturity or gestational age, or both.

The second weakness is that diagnosis code 769 (Respiratory distress syndrome in newborn) is currently only associated with DRG 386, which requires extreme prematurity, but respiratory distress syndrome in newborns can occur with all levels of prematurity. Therefore, we believe that code 769 should not be used to classify a diagnosis under DRG 386.

The proposed revision to DRG 386 would reflect the upcoming new ICD–9–CM diagnosis codes. We are proposing to redefine DRG 386 to include those newborns whose preterm birthweight is less than 1,000 grams or gestational age is less than 27–28 completed weeks, or both. Therefore, we would remove diagnosis code 769 from DRG 386, as this code is associated with all levels of prematurity, not just extreme immaturity. In addition, we are proposing to revise the title of DRG 386 to read ''Extreme Immaturity''.

Because birthweight for neonates varies at all gestational ages, some neonates will meet the DRG 386 criteria for preterm extremely low birthweight (less than 1,000 grams) but not the DRG 386 criteria for extremely short gestation age (less than 27–28 completed weeks). The reverse may also occur, where a neonate meets the DRG 386 criteria for extremely short gestational age (less than 27–28 completed weeks) but not for preterm extremely low birthweight (less than 1,000 grams). In either situation, the neonate would be assigned to the proposed retitled DRG 386 (Extreme Immaturity).

NACHRI provided the following information on the measurement of gestational age and its use in the definition of Medicare neonatal DRGs. First, they noted that gestational age can be as powerful a predictor of a newborn's hospitalization course as birthweight and corresponds more directly to organ system immaturity. Second, while gestational age can be identified with a reasonable level of accuracy, it cannot be measured as precisely as birthweight. These two considerations led NACHRI to recommend the inclusion of gestational age in the definition of the Medicare neonatal DRGs, but in a conservative manner. Specifically, extremely short gestational age, as identified earlier, usually implies gestational age less than 28 weeks. The proposed new definition of DRG 386 includes only the gestational age codes for less than 27 to 28 completed weeks. Thus, there is a 1-week conservative bias in the use of the new gestational age codes for DRG 386. It is also important to note that the existing DRG 386 definition includes existing codes 765.01 through 765.05, which include extreme immaturity without a specific identification of gestational age and birthweight up to 1,499 grams (3.3 pounds). Thus, the proposed revised definition of DRG 386 is actually somewhat more stringent as well as more specific.

To implement these changes, we are proposing to remove the following diagnosis codes from the list of ''principal or secondary diagnosis'' under DRG 386:

- 765.04, Extreme immaturity, 1,000–1,249 grams
- 765.05, Extreme immaturity, 1,250–1,499 grams
- 769, Respiratory distress syndrome in newborn

Note, as explained above, while we are proposing to remove diagnosis codes 765.04, 765.05, and 769 from the list of principal or secondary diagnosis under DRG 386, a neonate would still be assigned to DRG 386 if there is a diagnosis of gestational age less than 27 to 28 completed weeks reported (765.21 through 765.23).

We are proposing to add the following diagnosis codes to the list of ''principal or secondary diagnosis'' under DRG 386:

- 765.11, Other preterm infants, less than 500 grams
- 765.12, Other preterm infants, 500–749 grams
- 765.13, Other preterm infants, 750–999 grams
- 765.21, Less than 24 completed weeks of gestation
- 765.22, 24 completed weeks of gestation
- 765.23, 25–26 completed weeks of gestation

c. DRG 387 (Prematurity With Major Problems)

The existing definition of DRG 387 has the following three components: (1) Principal or secondary diagnosis of prematurity; (2) Principal or secondary diagnosis of major problem (these are diagnoses that define MDC 15); or (3) secondary diagnosis of major problem (these are diagnoses that do not define MDC 15 so they can only be secondary diagnosis codes for patients assigned to MDC 15). We are proposing changes for each component of the definition for DRG 387.

We are proposing to revise the definition for the first component of DRG 387, ''principal or secondary diagnosis of prematurity'', to include all preterm low birthweight codes with fifth digit range code values indicating birthweight between 1,000 grams (2.2 pounds) and 2,499 grams (5.5 pounds), or gestational age between 27 to 28 and 35 to 36 completed weeks, or both. This would include all of the preterm low birthweight and gestational age codes except those assigned to the proposed revised DRG 386 and except for the following four preterm and gestational age codes: 765.10, 765.19, 765.20, and 765.29.

It is possible for a neonate to be premature and greater than 2,500 grams (5.5 pounds). In this instance, one of the new gestational age codes that specifically identifies the newborn to be less than 37 completed weeks of gestation would need to be present to meet the criteria for inclusion in DRG 387. This is not a conceptual change for DRG 387, in that diagnosis codes 765.10 and 765.19 should both refer to newborns less than 37 completed weeks of gestation. Therefore, we are proposing to take into consideration the new ICD–9–CM codes that require a more specific affirmation that the newborn is less than 37 completed weeks of gestation. Because DRG 387 is a broadly defined category (1,000–2,499 grams or 27–36 completed weeks of gestation), NACHRI recommends that it is important to require specific information for inclusion of patients at the high end of the birthweight/gestational age range.

We are proposing to remove the following diagnosis codes from the list of diagnoses defined as ''principal or secondary diagnosis of prematurity'' for DRG 387:

- 765.10, Other preterm infants, unspecified (weight)

- 765.11, Other preterm infants, less than 500 grams
- 765.12, Other preterm infants, 500–749 grams
- 765.13, Other preterm infants, 750–999 grams
- 765.19, Other preterm infants, 2,500+ grams

We are proposing to add the following diagnosis codes to the list of diagnoses defined as ''principal or secondary diagnosis of prematurity'' for DRG 387:

- 765.04, Extreme immaturity, 1000–1249 grams
- 765.05, Extreme immaturity, 1250–1499 grams
- 765.24, 27–28 completed weeks of gestation
- 765.25, 29–30 completed weeks of gestation
- 765.26, 31–32 completed weeks of gestation
- 765.27, 33–34 completed weeks of gestation
- 765.28, 35–36 completed weeks of gestation

We are proposing to revise the definition for the second component of DRG 387, ''principal or secondary diagnosis of major problem'', to remove certain diagnosis codes and to add other diagnosis codes. We are proposing to remove three groups of diagnosis codes. The first group of diagnosis codes that we are proposing to remove includes the fetal malnutrition codes for the birthweight ranges less than 2500 grams. NACHRI indicates that these newborns are not necessarily more complicated than preterm infants of the same birthweight range. These newborns have fewer problems related to organ system immaturity and often demonstrate excellent catch-up growth after delivery. Some of the fetal malnutrition diagnosis neonates may have serious problems. Therefore, it is best for the classification system to look for other more specific, major problem diagnoses than to include all of these newborns in DRG 387. We are proposing to remove the following diagnosis codes from DRG 387.

- 764.11, ''Light-for-dates'' with signs of fetal malnutrition, less than 500 grams
- 764.12, ''Light-for-dates'' with signs of fetal malnutrition, 500–749 grams
- 764.13, ''Light-for-dates'' with signs of fetal malnutrition, 750–999 grams
- 764.14, ''Light-for-dates'' with signs of fetal malnutrition, 1,000–1,249 grams
- 764.15, ''Light-for-dates'' with signs of fetal malnutrition, 1,250–1,499 grams
- 764.16, ''Light-for-dates'' with signs of fetal malnutrition, 1,500–1,749 grams
- 764.17, ''Light-for-dates'' with signs of fetal malnutrition, 1,750–1,999 grams
- 764.18, ''Light-for-dates'' with signs of fetal malnutrition, 2,000–2,499 grams
- 764.21, Fetal malnutrition without mention of ''light-for-dates'', less than 500 grams
- 764.22, Fetal malnutrition without mention of ''light-for-dates'', 500–749 grams
- 764.23, Fetal malnutrition without mention of ''light-for-dates'', 750–999 grams
- 764.24, Fetal malnutrition without mention of ''light-for-dates'', 1,000–1,249 grams
- 764.25, Fetal malnutrition without mention of ''light-for-dates'', 1,250–1,499 grams
- 764.26, Fetal malnutrition without mention of ''light-for-dates'', 1,500–1,749 grams
- 764.27, Fetal malnutrition without mention of ''light-for-dates'', 1,750–1,999 grams
- 764.28, Fetal malnutrition without mention of ''light-for-dates'', 2,000–2,499 grams

The second group of codes we are proposing to remove from the list of ''principal or secondary diagnosis of major problems'' under DRG 387 consists of the following 13 diagnosis codes. The majority of these diagnosis codes do not represent a major problem for a newborn at or shortly after birth. NACHRI believes that costs associated with newborns with these conditions are similar to costs associated with neonates without a major problem.

- 763.4, Cesarean delivery affecting fetus or newborn
- 770.1, Meconium aspiration syndrome
- 770.8, Other newborn respiratory problems
- 771.8, Other infection specific to the perinatal period
- 772.0, Fetal blood loss
- 773.2, Hemolytic disease due to other and unspecified isoimmunization of fetus or newborn
- 773.5, Late anemia due to isoimmunization of fetus or newborn
- 775.5, Other transitory neonatal electrolyte disturbances
- 775.6, Neonatal hypoglycemia
- 776.0, Hemorrhagic disease of newborn
- 776.6, Anemia of prematurity
- 777.1, Meconium obstruction in fetus or newborn
- 777.2, Intestinal obstruction due to inspissated milk in newborn

We note that diagnosis code 770.8 (Other newborn respiratory problems) and diagnosis code 771.8 (Other infection specific to the perinatal period) are 4-digit codes that are being replaced by a series of more specific 5-digit codes, effective October 1, 2002. (See Table 6C in the Addendum of this proposed rule.) The listing of the codes on the second group above includes some of these new 5-digit codes.

The third group of diagnosis codes that we are proposing to remove from the list of diagnosis defined as ''principal or secondary diagnosis of major problem'' under DRG 387 includes the following two diagnosis codes. These codes are no longer assigned to MDC 15 when they are the principal diagnosis.

- 759.4, Conjoined twins
- 779.7, Periventricular leukomalacia

We are proposing to add the following nine new and existing diagnosis codes to the list of ''principal or secondary diagnosis of major problem'' that defines DRG 387. These nine diagnosis codes generally represent major problems at the time of birth and have costs more similar to those of neonates with major problems than neonates without major problems. Many of these diagnosis codes are related to congenital anomaly conditions.

- 747.83, Persistent fetal circulation (new code)
- 769, Respiratory distress syndrome in newborn
- 770.84, Respiratory failure of newborn (new code)
- 771.3, Tetanus neonatorum
- 771.81, Septicemia of newborn (new code)
- 771.82, Neonatal urinary tract infection (new code)
- 771.83, Bacteremia of newborn (new code)
- 771.89, Other infections specific to perinatal period (new code)
- 776.7, Transient neonatal neutropenia

Of special note is the handling of diagnosis code 769 (Respiratory distress syndrome in newborn). Earlier in this preamble, we discussed the proposed removal of this diagnosis code from the definition of proposed retitled DRG 386 (Extreme Immaturity) because, even though it is usually associated with prematurity, it may occur with all levels of prematurity. We are proposing to add respiratory distress syndrome (which was previously assigned to existing DRG 386) to the list of diagnoses that define ''principal or secondary diagnosis of major problem'' for DRG 387. We are not proposing to add it to the list of diagnoses that define ''principal or secondary diagnosis of prematurity'' for DRG 387. The rationale for not adding code 769 as a prematurity diagnosis is that it occurs in only a small subset of neonates in the birthweight range of 1,000 to 2,499 grams (2.2 to 5.5 pounds), and the vast majority of occurrences is in the upper end of this birthweight range. Respiratory distress syndrome

might not be indicative of a major problem for neonates at the low end of this range (for example, those closer to 1,000 to 1,249 grams), because these neonates will most likely have multiple significant problems. Therefore, we are proposing that respiratory distress syndrome be classified as a major problem and included among the list of ''principal or secondary diagnosis of major problem'' for DRG 387.

In addition, we are proposing to revise the definition for the third defining component of DRG 387, ''secondary diagnosis of major problem''. This list of major problem diagnoses can only be secondary diagnoses because they are not among the list of principal diagnoses that defines MDC 15 for the Medicare DRG classification system. Based on NACHRI's recommendations, we are proposing to add and remove diagnoses from this list on the same basis as previously described for the list of ''principal or secondary diagnosis of major problems'' for DRG 387. That is, diagnoses are removed if, in the majority of instances, the condition does not represent a major problem for a newborn at or shortly after birth, and on average exhibits costs similar to the costs associated with neonates without a major problem. In addition, we are proposing to remove the asthma with status asthmaticus diagnosis codes, as these diagnosis codes pertain to newborns or other conditions arising in the perinatal period.

We are proposing to remove the following diagnosis codes from the list of ''secondary diagnosis of major problem'' for DRG 387:

- 276.5, Volume depletion
- 349.0, Reaction to spinal or lumbar puncture
- 457.2, Lymphangitis
- 493.01, Extrinsic asthma with status asthmaticus
- 493.11, Intrinsic asthma with status asthmaticus
- 493.91, Asthma, unspecified type, with status asthmaticus
- 578.1, Blood in stool
- 683, Acute lymphadenitis
- 693.0, Dermatitis due to drugs and medicines taken internally
- 695.0, Toxic erythema
- 708.0, Allergic urticaria
- 745.4, Ventricular septal defect
- 785.0, Tachycardia, unspecified
- 995.2, Unspecified adverse effect of drug, medicinal and biological substance, not elsewhere classified
- 999.5, Other serum reaction, not elsewhere classified
- 999.6, ABO incompatibility reaction, not elsewhere classified
- 999.7, Rh incompatibility reaction, not elsewhere classified
- 999.8, Other transfusion reaction, not elsewhere classified

We are proposing to add the following 65 diagnosis codes to the list of ''secondary diagnosis of major problem'' for DRG 387:

- 416.0, Primary pulmonary hypertension
- 416.8, Other chronic pulmonary heart diseases
- 425.3, Endocardial fibroelastosis
- 425.4, Other primary cardiomyopathies
- 427.0, Paroxysmal supraventricular tachycardia
- 427.1, Paroxysmal ventricular tachycardia
- 466.11, Acute bronchiolitis due to respiratory syncytial virus (RSV)
- 466.19, Acute bronchiolitis due to other infectious organisms
- 478.74, Stenosis of larynx
- 480.0, Pneumonia due to adenovirus
- 480.1, Pneumonia due to respiratory syncytial virus
- 480.2, Pneumonia due to parainfluenza virus
- 480.8, Pneumonia due to other virus not elsewhere classified
- 480.9, Viral pneumonia, unspecified
- 745.0, Common truncus
- 745.10, Complete transposition of great vessels
- 745.11, Double outlet right ventricle
- 745.12, Corrected transposition of great vessels
- 745.19, Other transposition of great vessels
- 745.2, Tetralogy of Fallot
- 745.3, Common ventricle
- 745.60, Endocardial cushion defect, unspecified type
- 745.61, Ostium primum defect
- 745.69, Other endocardial cushion defects
- 746.01, Atresia of pulmonary valve, congenital
- 746.1, Tricuspid atresia and stenosis, congenital
- 746.2, Ebstein's anomaly
- 746.7, Hypoplastic left heart syndrome
- 746.81, Subaortic stenosis, congenital
- 746.82, Cor triatriatum
- 746.84, Obstructive anomalies of heart, congenital, not elsewhere classified
- 746.86, Congenital heart block
- 747.10, Coarctation of aorta (preductal) (postductal)
- 747.11, Interruption of aortic arch
- 747.41, Total anomalous pulmonary venous connection
- 747.81, Anomalies of cerebrovascular system, congenital
- 748.3, Other congenital anomalies of larynx, trachea, and bronchus
- 748.4, Cystic lung, congenital
- 748.5, Agenesis, hypoplasia, and dysplasia of lung, congenital
- 750.3, Tracheoesophageal fistula, esophageal atresia and stenosis, congenital
- 751.1, Atresia and stenosis of small intestine, congenital
- 751.2, Atresia and stenosis of large intestine, rectum, and anal canal, congenital
- 751.3, Hirschsprung's disease and other congenital functional disorders of colon
- 751.4, Anomalies of intestinal fixation, congenital
- 751.62, Congenital cystic disease of liver
- 751.69, Other congenital anomalies of gall bladder, bile ducts, and liver
- 751.7, Anomalies of pancreas, congenital
- 753.0, Renal agenesis and dysgenesis
- 753.5, Exstrophy of urinary bladder
- 756.51, Osteogenesis imperfecta
- 756.6, Anomalies of diaphragm, congenital
- 756.70, Congenital anomaly of abdominal wall, unspecified
- 756.71, Prune belly syndrome
- 756.79, Other congenital anomalies of abdominal wall
- 758.1, Patau's Syndrome
- 758.2, Edwards' Syndrome
- 758.3, Autosomal deletion syndromes
- 759.4, Conjoined twins
- 759.7, Multiple congenital anomalies, so described
- 759.81, Prader-Willi Syndrome
- 759.89, Other specified anomalies
- 7797, Periventricular leukomalacia
- 785.51, Cardiogenic shock
- 785.59, Other shock without mention of trauma
- 789.5, Ascites

d. DRG 388 (Prematurity Without Major Problems)

We are proposing to revise the definition for prematurity for DRG 388 ((Prematurity without Major Problems) in the same manner that we proposed to revise the definition of prematurity for DRG 387 (Prematurity with Major Problems).

We are proposing to remove the following five diagnosis codes from the list of codes pertaining to the ''principal or secondary diagnosis of prematurity'' for DRG 388:

- 765.10, Other preterm infants unspecified (weight)
- 765.11, Other preterm infants, less than 500 grams
- 765.12, Other preterm infants, 500–749 grams
- 765.13, Other preterm infants, 750–999 grams

- 765.19, Other preterm infants, 2,500+ grams

We are proposing to add the following seven diagnosis codes to the definition of principal or secondary diagnosis of prematurity for DRG 388:

- 765.04, Extreme immaturity, 1000–1249 grams
- 765.05, Extreme immaturity, 1250–1499 grams
- 765.24, 27–28 completed weeks of gestation
- 765.25, 29–30 completed weeks of gestation
- 765.26, 31–32 completed weeks of gestation
- 765.27, 33–34 completed weeks of gestation
- 765.28, 35–36 completed weeks of gestation

e. DRG 389 (Full Term Neonate With Major Problem)

We are proposing to revise the definition of ''principal or secondary diagnosis of major problem'' for DRG 389 (Full Term Neonate with Major Problem) in the same manner that we proposed to revise the definition for DRG 387 (Prematurity with Major Problem).

f. DRG 390 (Neonate With Other Significant Problems)

DRG 390 is defined as patients with ''principal or secondary diagnosis of newborn or neonate, with other significant problems, not assigned to DRG 385 through 389, 391, or 469 (principal diagnosis invalid as discharge diagnosis). As a result of our proposed changes to other neonatal DRGs, we are proposing to make conforming changes related to diagnosis codes assigned to DRG 390.

g. DRG 391 (Normal Newborn)

DRG 391 (Normal Newborn) is defined by a list of principal diagnoses (for example, V30, Newborn codes plus certain minor newborn problems) and no secondary diagnoses or only certain secondary diagnoses (that is, minor problem diagnoses). NACHRI recommended that the definition of DRG 391 be modified to expand the number of minor problem newborn diagnoses included in both the list of principal diagnoses and the list of only certain secondary diagnoses that define DRG 391. The diagnoses that we are proposing to add to DRG 391 are conditions that NACHRI has identified as occurring with some frequency in the newborn population and having costs more similar to that of DRG 391 than DRG 390 (Neonates with Other Significant Problems).

We are proposing to add the following diagnosis codes to the list of ''principal diagnosis'' that defines DRG 391:

- 764.00, ''Light-for-dates'' without mention of fetal malnutrition, unspecified (weight)
- 764.90, Fetal growth retardation unspecified (weight)
- 765.10, Other preterm infants unspecified (weight)
- 765.19, Other preterm infants, 2,500+ grams
- 765.20, Unspecified weeks of gestation
- 765.29, 37 or more completed weeks of gestation

We also are proposing to add the above six diagnosis codes to the list of ''only certain secondary diagnosis'' that defines DRG 391, as indicated below. Of these diagnosis codes, NACHRI indicates that the highest volume diagnosis code is 765.19 (Other preterm infants, 2,500+ grams). NACHRI notes that when this diagnosis code is recorded and no major problem or significant problem diagnosis is recorded, these patients have costs that are not much different than those for other normal newborns.

We are proposing to add the following codes to the list of ''only certain secondary diagnosis'' that defines DRG 391:

- 216.0, Benign neoplasm of skin of lip
- 216.1, Benign neoplasm of eyelid, including canthus
- 216.2, Benign neoplasm of ear and external auditory canal
- 216.3, Benign neoplasm of skin of other and unspecified parts of face
- 216.4, Benign neoplasm of scalp and skin of neck
- 216.5, Benign neoplasm of skin of trunk, except scrotum
- 216.6, Benign neoplasm of skin of upper limb, including shoulder
- 216.7, Benign neoplasm of skin of lower limb, including hip
- 216.8, Benign neoplasm of other specified sites of skin
- 216.9, Benign neoplasm of skin, site unspecified
- 228.00, Hemangioma of unspecified site
- 228.01, Hemangioma of skin and subcutaneous tissue
- 228.1, Lymphangioma, any site
- 379.8, Other specified disorders of eye and adnexa
- 379.90, Disorder of eye, unspecified
- 379.92, Swelling or mass of eye
- 379.93, Redness or discharge of eye
- 379.99, Other ill-defined disorders of eye
- 427.60, Premature beats, unspecified
- 427.61, Supraventricular premature beats
- 427.9, Cardiac dysrhythmia, unspecified
- 528.4, Cysts of oral soft tissues
- 553.1, Umbilical hernia without mention of obstruction or gangrene
- 603.8, Other specified types of hydrocele
- 603.9, Hydrocele, unspecified
- 607.89, Other specified disorders of penis
- 607.9, Unspecified disorder of penis and perineum
- 624.9, Unspecified noninflammatory disorder of vulva and perineum
- 692.9, Contact dermatitis and other eczema unspecified cause
- 701.1, Keratoderma, acquired
- 701.3, Striae atrophicae
- 701.8, Other specified hypertrophic and atrophic conditions of skin
- 701.9, Unspecified hypertrophic and atrophic conditions of skin
- 702.8, Other specified dermatoses
- 705.1, Prickly heat
- 706.1, Other acne
- 706.2, Sebaceous cyst
- 709.8, Other specified disorders of skin
- 709.9, Unspecified disorder of skin and subcutaneous tissue
- 719.61, Other symptoms referable to joint of shoulder region
- 719.65, Other symptoms referable to joint of pelvic region and thigh
- 755.00, Polydactyly, unspecified digits
- 755.01, Polydactyly of fingers
- 755.02, Polydactyly of toes
- 755.10, Syndactyly of multiple and unspecified sites
- 755.11, Syndactyly of fingers without fusion of bone
- 755.12, Syndactyly of fingers with fusion of bone
- 755.13, Syndactyly of toes without fusion of bone
- 755.14, Syndactyly of toes with fusion of bone
- 755.66, Other congenital anomalies of toes
- 755.67, Anomalies of foot, congenital, not elsewhere classified
- 755.9, Unspecified congenital anomaly of unspecified limb
- 757.2, Dermatoglyphic anomalies
- 757.32, Vascular hamartomas
- 757.39, Other specified congenital anomalies of skin
- 757.4, Specified congenital anomalies of hair
- 757.5, Specified congenital anomalies of nails
- 757.6, Specified congenital anomalies of breast
- 757.8, Other specified congenital anomalies of the integument
- 757.9, Unspecified congenital anomaly of the integument
- 760.0, Maternal hypertensive disorders affecting fetus or newborn

- 760.1, Maternal renal and urinary tract diseases affecting fetus or newborn
- 760.2, Maternal infections affecting fetus or newborn
- 760.3, Other chronic maternal circulatory and respiratory diseases affecting fetus or newborn
- 760.4, Maternal nutritional disorders affecting fetus or newborn
- 760.5, Maternal injury affecting fetus or newborn
- 760.6, Surgical operation on mother affecting fetus or newborn
- 760.70, Unspecified noxious substance affecting fetus or newborn via placenta or breast milk
- 760.74, Anti-infectives affecting fetus or newborn via placenta or breast milk
- 760.76, Diethylstilbestrol (DES) exposure affecting fetus or newborn via placenta or breast milk
- 760.79, Other noxious influences affecting fetus or newborn via placenta or breast milk
- 760.8, Other specified maternal conditions affecting fetus or newborn
- 760.9, Unspecified maternal condition affecting fetus or newborn
- 761.0, Incompetent cervix affecting fetus or newborn
- 761.1, Premature rupture of membranes affecting fetus or newborn
- 761.5, Multiple pregnancy affecting fetus or newborn
- 761.7, Malpresentation before labor affecting fetus or newborn
- 761.8, Other specified maternal complications of pregnancy affecting fetus or newborn
- 761.9, Unspecified maternal complication of pregnancy affecting fetus or newborn
- 762.8, Other specified abnormalities of chorion and amnion affecting fetus or newborn
- 762.9, Unspecified abnormality of chorion and amnion affecting fetus or newborn
- 763.4, Cesarean delivery affecting fetus or newborn
- 763.5, Maternal anesthesia and analgesia affecting fetus or newborn
- 763.7, Abnormal uterine contractions affecting fetus or newborn
- 763.89, Other specified complications of labor and delivery affecting fetus or newborn
- 764.00, ''Light-for-dates'' without mention of fetal malnutrition, unspecified (weight)
- 764.90, Fetal growth retardation unspecified (weight)
- 765.10, Other preterm infants unspecified (weight)
- 765.19, Other preterm infants, 2,500+ grams
- 765.20, Unspecified weeks of gestation
- 765.29, 37 or more completed weeks of gestation
- 767.2, Fracture of clavicle due to birth trauma
- 767.3, Other injuries to skeleton due to birth trauma
- 767.8, Other specified birth trauma
- 767.9, Unspecified birth trauma
- 768.2, Fetal distress before onset of labor, in liveborn infant
- 768.3, Fetal distress first noted during labor, in liveborn infant
- 768.4, Fetal distress, unspecified as to time of onset, in liveborn infant
- 768.9, Unspecified severity of birth asphyxia in liveborn infant
- 70.9, Unspecified respiratory condition of fetus and newborn
- 772.8, Other specified hemorrhage of fetus or newborn
- 772.9, Unspecified hemorrhage of newborn
- 773.1, Hemolytic disease due to ABO isoimmunization of fetus or newborn
- 773.2, Hemolytic disease due to other and unspecified isoimmunization of fetus or newborn
- 773.5, Late anemia due to isoimmunization of fetus or newborn
- 775.6, Neonatal hypoglycemia
- 775.9, Unspecified endocrine and metabolic disturbances specific to the fetus and newborn
- 776.4, Polycythemia neonatorum
- 776.8, Other specified transient hematological disorders of fetus or newborn
- 776.9, Unspecified hematological disorder specific to fetus or newborn
- 777.1, Meconium obstruction in fetus or newborn
- 777.3, Hematemesis and melena due to swallowed maternal blood of newborn
- 777.8, Other specified perinatal disorders of digestive system
- 777.9, Unspecified perinatal disorder of digestive system
- 778.3, Other hypothermia of newborn
- 778.4, Other disturbances of temperature regulation of newborn
- 778.6, Congenital hydrocele
- 778.7, Breast engorgement in newborn
- 778.9, Unspecified condition involving the integument and temperature regulation of fetus and newborn
- 779.9, Unspecified condition originating in the perinatal period
- 780.6, Fever
- 781.0, Abnormal involuntary movements
- 781.3, Lack of coordination
- 782.1, Rash and other nonspecific skin eruption
- 782.2, Localized superficial swelling, mass, or lump
- 782.4, Jaundice, unspecified, not of newborn
- 782.61, Pallo
- 782.62, Flushin
- 782.7, Spontaneous ecchymose
- 782.8, Changes in skin texture
- 782.9, Other symptoms involving skin and integumentary tissues
- 783.3, Feeding difficulties and mismanagement
- 784.2, Swelling, mass, or lump in head and neck
- 784.9, Other symptoms involving head and neck
- 785.2, Undiagnosed cardiac murmurs
- 785.3, Other abnormal heart sounds
- 785.9, Other symptoms involving cardiovascular system
- 786.00, Respiratory abnormality, unspecified
- 786.7, Abnormal chest sounds
- 786.9, Other symptoms involving respiratory system and chest
- 787.3, Flatulence, eructation, and gas pain
- 790.6, Other abnormal blood chemistry
- 790.7, Bacteremia
- 790.99, Other nonspecific findings on examination of blood
- 795.6, False positive serological test for syphilis
- 795.79, Other and unspecified nonspecific immunological findings
- 796.1, Abnormal reflex
- 910.0, Abrasion or frictions burn of face, neck, and scalp except eye, without mention of infection
- 910.2, Blister of face, neck, and scalp except eye, without mention of infection
- 910.8, Other and unspecified superficial injury of face, neck, and scalp, without mention of infection
- 920, Contusion of face, scalp, and neck except eye(s)
- 999.5, Other serum reaction, not elsewhere classified
- 999.6, ABO incompatibility reaction, not elsewhere classified
- V01.1, Contact with or exposure to tuberculosis
- V01.6, Contact with or exposure to venereal diseases
- V01.7, Contact with or exposure to other viral diseases
- V01.81, Contact with or exposure to communicable diseases, anthrax
- V01.89, Contact with or exposure to communicable diseases, other communicable diseases
- V01.9, Contact with or exposure to unspecified communicable disease
- V02.3, Carrier or suspected carrier of other gastrointestinal pathogens
- V05.3, Need for prophylactic vaccination and inoculation against viral hepatitis
- V05.4, Need for prophylactic vaccination and inoculation against varicella

- V05.8, Need for prophylactic vaccination and inoculation against other specified disease
- V05.9, Need for prophylactic vaccination and inoculation against unspecified single disease
- V07.8, Need for other specified prophylactic measure
- V07.9, Need for unspecified prophylactic measure
- V18.0, Family history of diabetes mellitus
- V18.1, Family history of other endocrine and metabolic diseases
- V18.2, Family history of anemia
- V18.3, Family history of other blood disorders
- V18.8, Family history of infectious and parasitic diseases
- V19.2, Family history of deafness or hearing loss
- V19.8, Family history of other condition
- V71.9, Observation for unspecified suspected condition
- V72.0, Examination of eyes and vision
- V72.6, Laboratory examination
- V73.89, Special screening examination for other specified viral diseases
- V73.99, Special screening examination for unspecified viral disease

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

In the August 1, 2001 final rule, we included in Table 6A—New Diagnosis Codes (66 FR 40064) code V10.53 (History of malignancy, renal pelvis), which was approved by the ICD–9–CM Coordination and Maintenance Committee as a new code effective October 1, 2001. We assigned the code to DRG 411 (History of Malignancy without Endoscopy) and DRG 412 (History of Malignancy with Endoscopy).

We received correspondence which suggested that we should have also assigned code V10.53 to DRG 465 (Aftercare with History of Malignancy as Secondary Diagnosis). The correspondent pointed out that all other codes for a history of malignancy are included in DRG 465.

We agree that code V10.53 should be included in the list of the history of malignancy codes within DRG 465. Therefore, we are proposing to add V10.53 to the list of secondary diagnosis in DRG 465.

8. Pre-MDC: Tracheostomy

DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses) is used to classify patients who require long-term mechanical ventilation. Mechanical ventilation can be administered through an endotracheal tube for a limited period of time. When an endotracheal tube is used for an extended period of time (beyond 7 to 10 days), the patient runs a high risk of permanent damage to the trachea. In order to maintain a patient on mechanical ventilation for a longer period of time, the endotracheal tube is removed and a tracheostomy is performed. The mechanical ventilation is then administered through the tracheostomy.

A tracheostomy also may be performed on patients for therapeutic purposes unrelated to the administration of mechanical ventilation. Patients with certain face, mouth, and neck disease may have a tracheostomy performed as part of the treatment for the face, mouth, or neck disease. These patients are assigned to DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses).

Therefore, patients assigned to DRGs 482 and 483 are differentiated based on the principal diagnosis of the patient. At certain times, selecting the appropriate principal diagnosis for the patients receiving tracheostomies for assignment to a DRG can be difficult. The overall number of tracheostomy patients increased by 13 percent between 1994 and 1999. During the same period, the percent of tracheostomy patients in DRG 483 (patients without certain face, mouth, or neck diseases) versus DRG 482 increased from 83.6 percent to 87.6 percent.

The payment weight for DRG 483 is more than four times greater than the DRG 482 payment weight, and this has led to concerns about coding compliance. Specifically, the fact that cases are assigned to DRG 483 based on the absence of a code indicating face, mouth, or neck diagnosis creates an incentive to omit codes indicating these diagnoses.

To address issues of possible coding noncompliance, we are proposing to modify DRGs 482 and 483 to differentiate the assignment to either DRG based on the presence or absence of continuous mechanical ventilation that lasts more than 96 hours (code 96.72). This modification would ensure that the patients assigned to DRG 483 are patients who had the tracheostomy for long-term mechanical ventilation. Based on an examination of claims data from the FY 2001 MedPAR file, we found that many patients assigned to DRG 483 do not have the code 96.72 for mechanical ventilation greater than 96 hours recorded. In part, this is the result of the limited number of procedure codes (six) that can be submitted on the current uniform hospital claim form, and the fact that code 96.72 does not currently affect the DRG assignment.

We found that many of the patients who are assigned to DRG 483 have multiple procedures, making it impossible for all procedures performed to be submitted on the hospital claim form. Because of the current underreporting of code 96.72 for continuous mechanical ventilation greater than 96 hours, we do not believe we can accurately determine the payment weights for modified DRGs 482 and 483 as described above.

In order to encourage the reporting of the code 96.72 for continuous mechanical ventilation for greater than 96 hours, we are proposing to change the definition of DRG 483 so that patients who have a tracheostomy and continuous mechanical ventilation greater than 96 hours (code 96.72) with a principal diagnosis unrelated to disease of the face, mouth, or neck would be assigned to DRG 483. DRG 483 would be retitled ''Tracheostomy/ Mechanical Ventilation 96+ Hours Except Face, Mouth, and Neck Diagnosis.''

We will give future consideration to modifying DRGs 482 and DRG 483 based on the presence of code 96.72, and invite comments on this area.

9. Medicare Code Editor (MCE) Change

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

The MCE includes an edit for ''nonspecific principal diagnosis'' that identifies a group of codes that are valid according to the ICD–9–CM coding scheme, but are not as specific as the coding scheme permits. The fiscal intermediaries use cases identified in this edit for educational purposes for hospitals only. That is, when a hospital reaches a specific threshold of cases (usually 25) in this edit, the fiscal intermediary will contact the hospital and educate it on how to code diagnoses using more specific codes in the ICD–9–CM coding scheme. The claims identified in this nonspecific principal diagnosis edit are neither denied nor returned to the hospital.

Code 436 (Acute, but ill-defined, cerebrovascular disease) is one of the codes included in the groups of codes identified in the nonspecific principal diagnosis edit, and is widely used in smaller hospitals where testing mechanisms are not available to more specifically identify the location and condition of cerebral and precerebral vessels. Because of the frequent use of code 436 among smaller hospitals, we

are proposing to remove the code from the nonspecific principal diagnosis edit in the MCE. We address the use of code 436 in section II.B.3. of this proposed rule under the discussion of MDC 5 changes with regard to the remodeling of DRGs 14 and 15.

10. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. 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 recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

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

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER 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 charge is ordered above a surgical class with a higher average charge. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, 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 charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, as a result of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

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

At this time, we are proposing to revise the surgical hierarchy for the pre-MDC DRGs and for MDC 5 (Diseases and Disorders of the Circulatory System) as follows:

- In the pre-MDC DRGs, we are proposing to reorder DRG 495 (Lung Transplant) above DRG 512 (Simultaneous Pancreas/Kidney Transplant).
- In MDC 5, we are proposing to reorder DRG 525 (Heart Assist System Implant) above DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with and without Cardiac Catheterization, respectively).

11. Refinement of Complications and Comorbidities (CC) List

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

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

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

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be

considered CCs of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions, the August 1, 2000 final rule (65 FR 47064) for the FY 2001 revisions; and the August 1, 2001 final rule (66 FR 39851) for the FY 2002 revisions. In the July 30, 1999 final rule (64 FR 41490), we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

We are proposing a limited revision of the CC Exclusions List to take into account the proposed changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2002. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this proposed rule contain the revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2002. 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, 2002, the indented diagnoses would not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2002, the indented diagnoses would be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, and 2002) and those in Tables 6F and 6G of the final rule for FY 2003 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, 2002. (Note: There was no CC Exclusions List in FY 2001 because we did not make changes to the ICD–9-CM codes for FY 2001.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 19.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 20.0 of this manual, which includes the final FY 2002 DRG changes, is available for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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

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

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

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.

We 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. Therefore, we are not proposing to move any procedures from DRG 477 to one of the surgical DRGs. However, we have identified a number of procedure codes that should be removed from DRG 468 and put into more clinically coherent DRGs. The proposed assignments of these codes are specified in the charts below.

MOVEMENT OF PROCEDURE CODES FROM DRG 468

Procedure Code	Description	Included in DRG	Description
MDC 6—Diseases and Disorders of the Digestive System			
387	Interruption vena cava	170	Other Digestive System O.R. Procedures with CC.
387	Interruption vena cava	171	Other Digestive System O.R. Procedures without CC.
3950	Angioplasty or atherectomy of noncoronary vessel ..	170	Other Digestive System O.R. Procedures with CC.
3950	Angioplasty or atherectomy of noncoronary vessel ..	171	Other Digestive System O.R. Procedures without CC.
MDC 7—Diseases and Disorders of the Hepatobiliary System and Pancreas			
387	Interruption vena cava	201	Other Hepatobiliary & Pancreas Procedures.
3949	Other revision of vascular procedure	201	Other Hepatobiliary & Pancreas Procedures.
3950	Angioplasty or atherectomy of noncoronary vessel ..	201	Other Hepatobiliary & Pancreas Procedures.
MDC 8—Diseases and Disorders of the Musculoskeletal System and Connective Tissue			
387	Interruption vena cava	233	Other Musculoskeletal System & Connective Tissue O.R. Procedures with CC.
387	Interruption vena cava	234	Other Musculoskeletal System & Connective Tissue O.R. Procedures without CC.
3950	Angioplasty or atherectomy of noncoronary vessel ..	233	Other Musculoskeletal System & Connective Tissue O.R. Procedures with CC.
3950	Angioplasty or atherectomy of noncoronary vessel ..	234	Other Musculoskeletal System & Connective Tissue O.R. Procedures without CC.
MDC 9—Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast			
8344	Other fasciectomy	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8344	Other fasciectomy	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
8345	Other myectomy	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8345	Other myectomy	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
8382	Muscle or fascia graft	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8382	Muscle or fascia graft	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
MDC 10—Endocrine, Nutritional and Metabolic Diseases and Disorders			
387	Interruption vena cava	292	Other Endocrine, Nutritional, & Metabolic O.R. Procedures with CC.
387	Interruption vena cava	293	Other Endocrine, Nutritional, & Metabolic O.R. Procedures without CC.
5459	Other Lysis of Peritoneal adhesions	292	Other Endocrine, Nutritional, & Metabolic O.R. Procedures with CC.
5459	Other Lysis of Peritoneal adhesions	293	Other Endocrine, Nutritional, & Metabolic O.R. Procedures without CC.
MC 11—Diseases and Disorders of the Kidney and Urinary Tract			
0492	Implantation or replacement of peripheral neurostimulator.	315	Other Kidney & Urinary Tract O.R. Procedures.
3821	Blood vessel biopsy	315	Other Kidney & Urinary Tract O.R. Procedures.
387	Interruption vena cava	315	Other Kidney & Urinary Tract O.R. Procedures.
3949	Other revision of vascular procedure	315	Other Kidney & Urinary Tract O.R. Procedures.

MOVEMENT OF PROCEDURE CODES FROM DRG 468—Continued

Procedure Code	Description	Included in DRG	Description
MDC 12—Diseases and Disorders Male Reproductive System			
387	Interruption vena cava	344	Other Male Reproductive System O.R. Procedures for Malignancy.
387	Interruption vena cava	345	Other Male Reproductive System O.R. Procedures Except for Malignancy.
8622	Excisional debridement of wound, infection, or burn	344	Other Male Reproductive System O.R. Procedures for Malignancy.
8622	Excisional debridement of wound, infection, or burn	345	Other Male Reproductive System O.R. Procedures Except for Malignancy.
MDC 13—Diseases and Disorders of the Female Reproductive System			
387	Interruption vena cava	365	Other Female Reproductive System O.R. Procedures.
MDC 16—Diseases and Disorders of the Blood, Blood Forming Organs, Immunological Disorders			
387	Interruption vena cava	394	Other O.R. Procedures of the Blood & Blood Forming Organs.

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

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

c. Adding Diagnosis Codes to MDCs

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

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

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

The 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 2003 at public meetings held on May 17 and 18, 2001, and November 1 and 2, 2001, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 8, 2002.

Copies of the Coordination and Maintenance Committee minutes of the 2001 meetings can be obtained from the CMS home page at: *http://www.cms.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; C4–08–06; 7500 Security Boulevard; Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *pbrooks@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2002. The new ICD–

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

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, 2002. 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. There are no invalid procedure codes for FY 2002 (Table 6D). Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Revisions to procedure code titles are in Table 6F (Revised Procedure Codes Titles).

14. Other Issues

In addition to the specific topics discussed in section II.B.1. through 13. of this proposed rule, we examined a number of other DRG-related issues. Below is a summary of the issues that were addressed. However, we are not proposing any changes at this time.

a. Intestinal Transplantation

We examined our data to determine whether it is appropriate to propose a new intestinal transplant DRG. There were nine intestinal transplantation cases reported by two facilities. Two of the cases involved a liver transplant during the same admission and, therefore, would be assigned to DRG 480 (Liver Transplant). We do not believe that this is a sufficient sample size to warrant the creation of a new DRG.

b. Myasthenia Gravis

Myasthenia Gravis is an autoimmune disease manifested by a syndrome of fatigue and exhaustion of the muscles that is aggravated by activity and relieved by rest. The weakness of the muscles can range from very mild to life-threatening.

This disease is classified to ICD–9–CM diagnosis code 358.0 and is assigned to DRG 12 (Degenerative Nervous System Disorders). Myasthenia Gravis in crisis patients is being treated with extensive plasmapheresis. We received a request to analyze the charges associated with Myasthenia Gravis in crisis patients receiving plasmapheresis to determine whether DRG 12 is an equitable DRG assignment for these cases. We are currently unable to differentiate between the mild and severe forms of this disease because all types are classified to code 358.0. Therefore, we have requested the NCHS to create a new diagnosis code for Myasthenia Gravis in crisis so that we can uniquely identify these cases to ensure the DRG assignment is appropriate.

c. Cardiac Mapping and Ablation

In the August 1, 2001 final rule (66 FR 39840), in response to a comment received, we agreed to continue to evaluate DRGs 516 (Percutaneous Cardiovascular Procedure with Acute Myocardial Infarction (AMI)), 517 (Percutaneous Cardiovascular Procedure with Coronary Artery Stent without AMI), and 518 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI) in MDC 5. We reviewed code 37.26 (Cardiac electrophysiologic stimulation and recording studies), code 37.27 (Cardiac mapping), and code 37.34 (Catheter ablation of lesion or tissues of heart). The commenter had recommended that CMS either create a separate DRG for cardiac mapping and ablation procedures, or assign codes 37.27 and 37.34 to DRG 516 after retitling the DRG. We have reviewed FY 2001 MedPAR data on these specific codes. Over 97 percent of cases with these codes were assigned to DRG 518 and had average charges of $1,741 below the average for all cases in the DRG. Therefore, the data do not support making any DRG changes for these procedure codes.

d. Aortic Endograft

In the August 1, 2001 final rule (66 FR 39841), we responded to a comment concerning the placement of aortic endografts in DRG 110 (Major Cardiovascular Procedures with CC) and DRG 111 (Major Cardiovascular Procedures without CC). The commenter noted that the cost of the device alone is greater than the entire payment for DRG 111 and recommended that these cases be assigned specifically to DRG 110. Our response at that time was that DRGs 110 and 111 are paired DRGs, differing only in the presence or absence of a CC.

We reviewed the MedPAR data again for FY 2001 using the following criteria: all cases were either in DRG 110 or 111, had a principal diagnosis of 441.4 (Abdominal aneurysm without mention of rupture), and included procedure code 39.71 (Endovascular implantation of graft in abdominal aorta). Our conclusion is that the majority of aneurysm cases are already grouped to DRG 110, where they are appropriately compensated. Therefore, we are not proposing to assign cases without CCs from DRG 111 to DRG 110. We reiterate that hospitals should code their records completely and record and submit all relevant diagnosis and procedure codes that have a bearing on the current admission (in particular, any complications or comorbidities associated with a case).

e. Platelet Inhibitors

In the August 1, 2002 final rule (66 FR 39840), we addressed a commenter's concern that modifications to MDC 5 involving percutaneous cardiovascular procedures would fail to account for the use of GP IIB–IIIA platelet inhibiting drugs for cases with acute coronary syndromes. GROUPER does not recognize procedure code 99.20 (Injection or infusion of platelet inhibitor) as a procedure. Therefore, its presence on a claim does not affect DRG assignment. We agreed to continue to evaluate this issue.

We reviewed cases in the FY 2001 MedPAR file for DRG 121 (Circulatory Disorders with AMI and Major Complication, Discharged Alive), DRG 122 (Circulatory Disorders with AMI without Major Complication, Discharged Alive) and DRGs 516, 517, and 518. We looked at all cases in these DRGs containing procedure code 99.20 by total number of procedures and by average charges. There were a total of 73,480 cases where platelet inhibitors were administered, with 70,216 of these cases in DRGs 516, 517, and 518. The average charges for platelet inhibitor cases in these three DRGs are actually slightly below the average for all cases in the respective DRGs. Therefore, we believe these cases are appropriately placed in the current DRGs, and are not proposing any changes to the assignment of these procedure codes.

f. Drug-Eluting Stents

The drug-eluting stents technology has been developed to combat the problem of restenosis of previously treated blood vessels. The drug is placed onto the stent with a special polymer

and slowly released into the vessel wall tissue over a period of 30 to 45 days, and is intended to prevent the build-up of scar tissue that can narrow the reopened artery.

In Table 6B of the Addendum to this proposed rule, we list a new procedure code 36.07 (Insertion of drug-eluting coronary artery stents(s)) that will be effective for use October 1, 2002. We also are proposing to add code 00.55 (Insertion of drug-eluting noncoronary artery stent).

A manufacturer of this technology requested that code 36.07 be assigned to DRG 516 (Percutaneous Cardiovascular Procedure with Acute Myocardial Infarction (AMI)) even without the presence of AMI. The manufacturer asserted that this technology is significantly more costly than other technologies currently assigned to DRG 517 (Percutaneous Cardiovascular Procedure with Coronary Artery Stent without AMI) (average charges of $29,189 compared to average charges of $22,998), and warrants this DRG assignment.

In addition, the manufacturer argued that this technology should be given preferential treatment because it will fundamentally change the treatment of multivessel disease. Specifically, the manufacturer stated that due to the absence of restenosis in patients treated with the drug-eluting stents based on the preliminary trial results, bypass surgery may no longer be the preferred treatment for many patients.[1] The manufacturer believes lower payments due to the decline in Medicare bypass surgeries will offset the higher payments associated with assigning all cases receiving the drug-eluting stent to DRG 516.

Currently, this technology has not been approved for use by the FDA. If the technology is approved by the FDA and further evidence is presented to us regarding the clinical efficacy and the impact that this technology has on the treatment of multivessel disease, we may reassign this code to another DRG or reassess the construct of all affected DRGs. We also are specifically soliciting comments on our proposal to treat the new codes cited above consistent with the current DRG assignment for stents.

g. Cardiac Resynchronization Therapy

Cardiac resynchronization therapy for heart failure provides strategic electrical stimulation to the right atrium, right ventricle, and left ventricle, in order to coordinate ventricular contractions and improve cardiac output. This therapy includes cardiac resynchronization therapy pacemakers (CRT–P) and cardiac resynchronization therapy defibrillators (CRT–D). While similar to conventional pacemakers and internal cardioverter-defibrillators, cardiac resynchronization therapy is different because it requires the implantation of a special electrode within the coronary vein, so that it can be attached to the exterior wall of the left ventricle.

Currently, defibrillator cases are assigned to either DRG 514 (Cardiac Defibrillator Implant with Cardiac Catheterization) or DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization). DRG 514 has a higher relative weight than DRG 515. We received a recommendation that we assign implantation of CRT–D (code 00.51, effective October 1, 2002) to either DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization) or DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization). It is argued that the change should be made because the current DRG structure for cardioverter-defibrillator implants does not recognize the significant amount of additional surgical resources required for cases involving patients with heart failure.

The recommendation supported assigning new code 00.50 (Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT–P]) to DRG 115 (Permanent Cardiac Pacemaker Implantation With AMI, Heart Failure, or Shock, or AICD Lead or Generator Procedure). Currently, pacemaker implantation procedures are assigned to either DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure, or Stroke, or AICD Lead or Generator Procedure) or DRG 116 (Other Permanent Cardiac Pacemaker Implant). DRG 115 has the higher relative weight. Because DRG 115 recognizes patients with heart failure, the manufacturer believed CRT–P cases would be appropriately classified to DRG 115.

Our proposed DRG assignment for code 00.51 would be to DRG 514 or 515. Our proposed DRG assignment for code 00.50 would be to DRG 115 and 116. However, we are soliciting comments on these proposed DRG assignments and will carefully consider any relevant evidence about the clinical efficacy and costs of this technology.

h. Hip and Knee Revisions

We received a request to consider assigning hip and knee revisions (codes 81.53 and 81.55) out of DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) because these revisions are significantly more resource intensive and costly than initial insertions of these joints.

We examined claims data and concluded that, while the charges for the hip and knee revision cases were somewhat higher than other cases within DRG 209, they do not support the establishment of a separate DRG.

i. Multiple Level Spinal Fusions

We received a comment suggesting that we create new spinal fusion DRGs that differentiate by the number of discs that are fused in a spinal fusion. The commenter indicated that the existing ICD–9–CM codes do not identify the number of discs that are fused. Codes were modified for FY 2002 to clearly differentiate between fusions and refusions, and new codes were created for the insertion of interbody spinal fusion device (84.51), 360 degree spinal fusion, single incision approach (81.61), and the insertion of recombinant bone morphogenetic protein (84.52) (66 FR 39841 through 39844).

ICD–9–CM codes have not historically been used to differentiate among cases by the number of repairs or manipulations performed in the course of a single procedure. However, we will explore the possibility of creating codes to differentiate cases by the number of discs fused during a spinal fusion procedure at the scheduled April 18 and 19, 2002 meeting of the ICD–9–CM Coordination and Maintenance Committee.

We also note that DRGs generally do not segregate cases based on the number of repairs or devices that occur in the course of a single procedure. For instance, DRGs are not split based on the number of vessels bypassed in cardiac surgery, nor are they split based on the number of cardiac valves repaired. Therefore, we are not proposing DRG changes for multiple level spinal fusions in this proposed rule.

j. Open Wound of the Hand

We received a recommendation that we move code 882.0 (Open Wound of Hand Except Finger(s) Alone Without Mention of Complication) from its current location in MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast) under DRGs 280 through 282 (Trauma to the Skin, Subcutaneous Tissue and Breast Age >17 with CC, Age >17 without CC, and Age 0–17, respectively) into MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs) under DRGs 444 through 446 (Traumatic Injury Age >17 with CC, Age

[1] ''Comparison of Coronary-Artery Bypass Surgery and Stenting for the Treatment of Multiveasel Disease,'' Serruys, P. W., Unger, F., et. al., *The New England Journal of Medicine,* April 12, 2001, Vol. 344, No. 15, p. 1117.

>17 without CC, and Age 0–17, respectively).

In examining our data, we found relatively few cases with code 882.0. These cases had charges that were less than the average charges for DRGs to which they are currently assigned. The data do not support a DRG change. Our medical consultants also believe that the cases are appropriately assigned to DRGs 280 through 282.

k. Cavernous Nerve Stimulation

As discussed in August 1, 2001 final rule (66 FR 39845), we reviewed data in MDC 12 (Diseases and Disorders of the Male Reproductive System). We looked specifically for code 89.58 (Plethysmogram) in DRG 334 (Major Male Pelvic Procedures with CC), and DRG 335 (Major Male Pelvic Procedures without CC).

Our data show that very few (six) of these procedures were reported on FY 2001 claims. It is not clear whether the small number reflects the fact that the procedure is not being performed, the ICD–9–CM code is not recorded, or the code is recorded but it is not in the top six procedures being performed. However, in all six cases where this procedure was performed, it occurred in conjunction with radical prostatectomy, so we are confident that these cases are consistent with the DRGs to which they have been grouped. Therefore, we are not proposing any DRG assignment changes to code 89.58 or DRGs 334 and 335.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 2003 recalibration as we did for FY 2002 (August 1, 2001 final rule (66 FR 39828)). That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we are proposing to use the most current charge information available, the FY 2001 MedPAR file. (For the FY 2002 recalibration, we used the FY 2000 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

FY 2001 MedPAR data include discharges occurring between October 1, 2000 and September 30, 2001, based on bills received by CMS through December 31, 2001, from all hospitals subject to the acute care hospital inpatient prospective payment system and short-term acute care hospitals in waiver States. The FY 2001 MedPAR file includes data for approximately 11,420,001 Medicare discharges. The data include hospitals that subsequently became CAHs, although no data are included for hospitals after the point they are certified as CAHs. Section IX. of this preamble contains information about how to obtain the MedPAR data.

The proposed methodology used to calculate the DRG relative weights from the FY 2001 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. (See section IX.A.15. of this proposed rule for information on the availability of the prospective payment system standardizing file.)
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- 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.
- 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 DRGs 512 (Simultaneous Pancreas/Kidney Transplant) and 513 (Pancreas Transplant). Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to exclude them from the relative weights for these DRGs. 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 used that same case threshold in recalibrating the proposed DRG weights for FY 2003. Using the FY 2001 MedPAR data set, there are 41 DRGs that contain fewer than 10 cases. We computed the weights for these 41 low-volume DRGs by adjusting the FY 2002 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The proposed new weights are normalized by an adjustment factor (1.43430) 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.

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

D. Proposed Add-On Payments for New Services and Technologies

1. Background

Section 533(b) of Public Law 106–554 amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) to establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges . . . is inadequate.'' Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered ''new'' if it meets criteria established by the Secretary (after notice and opportunity for public comment).

In the September 7, 200l final rule (66 FR 46902), we established that a new technology would be an appropriate candidate for an additional payment when it represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries (§ 412.87(b)(1)).

We also established that new technologies meeting this clinical definition must be demonstrated to be inadequately paid otherwise under the DRG system to receive special payment treatment (§ 412.87(b)(3)). To assess whether technologies would be inadequately paid under the DRGs, we established this threshold at one standard deviation beyond the geometric mean standardized charge for all cases in the DRGs to which the new technology is assigned (or the case-weighted average of all relevant DRGs, if the new technology occurs in many different DRGs) (§ 412.87(b)(3)).

Table 10 in the Addendum to this proposed rule lists the proposed qualifying criteria by DRG based on the discharge data used to calculate the proposed FY 2003 DRG weights. The thresholds published in the final rule will be used to evaluate applicants for new technology add-on payments during FY 2004 (beginning October 1, 2003). Similar to the timetable for applying for new technology add-on payments during FY 2003, we are proposing that applicants for FY 2004 must submit a significant sample of the data no later than early October 2002. Subsequently, we are proposing that a complete database must be submitted no later than mid-December 2002.

In addition to the clinical and cost criteria, we established that, in order to qualify for the special payment treatment, a specific technology must be ''new'' under the requirements of § 412.87(b)(2) of our regulations. The statutory provision contemplated the special payment treatment for new technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration (no less than 2 years and no more than 3 years). There is a lag of 2 to 3 years from the point a new technology is first introduced on the market and when data reflecting the use of the technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2001 are used to calculate the proposed FY 2003 DRG weights in this proposed rule.

Technology may be considered ''new'' for purposes of this provision within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the technology. After CMS has recalibrated the DRGs to reflect the costs of an otherwise new technology, the special add-on payment for new technology will cease (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2001 would be eligible to receive add-on payments as a new technology until FY 2004 (discharges occurring before October 1, 2003), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2004 DRG weights will be calculated using FY 2002 MedPAR data, the costs of such a new technology would be reflected in the FY 2004 DRG weights.

For technologies that do not qualify for special payments under § 412.87, we will continue our past practice of evaluating whether existing procedures are appropriately classified to a DRG. To the extent the introduction of a new code for existing technology helps to better identify higher costs associated with a procedure, we would work to expedite the appropriate assignment of that code (for example, using more recent MedPAR data).

In the September 7, 2001 final rule, we established that Medicare would provide higher payments for cases with higher costs involving identified new technologies, while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new technology. Under § 412.88, Medicare would pay a marginal cost factor of 50 percent for the costs of the new technology in excess of the full DRG payment. If the costs of a new technology case exceed the DRG payment by more than the estimated costs of the new technology, Medicare payment would be limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

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

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

To appropriately balance Congress' intent to increase Medicare's payments for eligible new technologies with concern that the total size of those payments not result in significantly reduced payments for other cases, we set a target limit for estimated special payments for new technology under the provisions of section 533(b) of Public Law 106–554 at 1.0 percent of estimated total operating prospective payments.

If invoked, the target limit would reduce the level of payments for approved technologies across the board,

to ensure estimated payments do not exceed the limit. Using this approach, all cases involving approved new technologies that would otherwise receive additional payments would still receive special payments, albeit at a reduced amount. Although the marginal payment rate for individual technologies will be reduced, this would be offset by large overall payments to hospitals for new technologies under this provision.

2. Applicants for FY 2003

We received five applications for new technologies to be designated eligible for inpatient add-on payments under the policy we implemented in the September 7, 2001 final rule. One of these applications was subsequently withdrawn. The remaining four applicants are discussed below.

a. Drotrecogin Alfa (Activated)—Xigris ™

Eli Lilly and Company (Lilly) developed drotrecogin alfa (activated), trade name Xigris™, as a new technology and submitted an application to us for consideration under the new technology add-on provision. Xigris™ is used to treat patients with severe sepsis.

According to the application—

''Approximately 750,000 cases of sepsis associated with acute organ dysfunction (severe sepsis) occur annually in the United States. The mortality rates associated with severe sepsis in the United States range from 28 percent to 50 percent and have remained essentially unchanged for several decades. Each year, 215,000 deaths are associated with severe sepsis; deaths after acute myocardial infarction occur at approximately an equal rate.''

Xigris™ is a biotechnology product that is a recombinant version of naturally occurring Activated Protein C (APC). APC is needed to ensure the control of inflammation and clotting in the blood vessels. In patients with severe sepsis, Protein C cannot be converted in sufficient quantities to the activated form. It appears that Xigris™ has the ability to bring blood clotting and inflammation back into balance and restore blood flow to the organs.

In support of its application, Lilly submitted data from the Phase III Protein C Worldwide Evaluation in Severe Sepsis (PROWESS) trial. According to Lilly, this was ''an international, multicenter, randomized, double-blind, placebo-controlled trial in which 1,690 patients with severe sepsis received either placebo (n = 840) or drotrecogin alfa (activated) (n = 850).'' The results of the trial were published in an article in the March 8, 2001 edition of *The New England Journal of Medicine* (Bernard, G. R., Vincent, J. L., et. al., ''Efficacy and Safety of Recombinant Human Activated Protein C for Severe Sepsis,'' Vol. 344, No, 10, p. 699).

A 6.1 percent reduction in mortality was reported. This conclusion was based on a measure of 28-day all-cause mortality. However, at 28 days, over 10 percent of the study participants were still hospitalized. Whether these patients subsequently went on to recover or died was not reported.

Because the reduction in mortality was the result of a treatment effect in a relatively small number of patients and mortality was looked at only 28 days after treatment, we plan to review unpublished data on all-cause mortality at the time of hospital discharge for all patients enrolled in the study using an intent-to-treat analysis. We have asked the trial sponsor to provide CMS with these unpublished data and the analyses performed in the original report, including confidence intervals and Kaplan-Meier curve with log-rank statistics, for death from any cause assessed at the time of hospital discharge. A small increase in the number of deaths among treated patients still hospitalized at 28 days could nullify the survival advantage attributed to the use of Xigris™.

The study had a number of other important methodological limitations that also merit further consideration. Therefore, we are unable to conclude, based on the published data, that Xigris™ represents an advance that substantially improves, relative to technology previously available, treatment for Medicare beneficiaries. However, we are continuing our assessment and will announce our final determination in the final rule. If we subsequently determine that Xigris™ represents a substantial improvement, payment would likely be limited to a subpopulation of patients with severe sepsis, consistent with the FDA labeling and possible other restrictions.

Detailed bills were available for 604 of 705 patients in the United States in the PROWESS clinical trial (303 placebo patients and 301 treatment patients). In all, 83 hospitals submitted detailed bills. These data included an indicator whether the patient received the treatment or a placebo, total charges and standardized charges for the stay as well as for the biological, and the patients' APACHE II scores (an assessment of the risk of mortality based on *a*cute *p*hysiology *a*nd *c*hronic *h*ealth *e*valuation). The FDA's approval letter (issued November 21, 2001) stated ''drotrecogin alfa (activated) is indicated for the reduction of mortality in adult patients with severe sepsis (sepsis associated with acute organ dysfunction) who have a high risk of death (e.g., as determined by APACHE II).''

Of the 604 cases with detailed billing data, 274 were patients age 65 or older. The average total charge for these 274 cases, including the average standardized charge for the biological, was $86,184 (adjusted for inflation using the applicable hospital market baskets, as patients were enrolled in the trial from July 1998 through June 2000). The inflated average standardized charge of the biological only for these cases was $15,562.

Lilly also submitted detailed ICD–9–CM diagnosis and procedure codes for a subset of 157 of the 604 U.S. patients with billing data from the PROWESS trial. These data were not requested as part of the trial, but were sent in separately. Of these 157 patients, 82 were over 65 years of age. These 82 patients grouped into 23 DRGs. Approximately 75 percent of these 82 cases were in 5 DRGs: 29 percent were in DRG 475 (Respiratory System Diagnosis with Ventilator Support); 17 percent were in DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses); 15 percent were in DRG 416 (Septicemia Age >17); 7 percent were in DRG 415 (OR Procedure for Infectious and Parasitic Diseases); and 5 percent were in DRG 148 (Major Small and Large Bowel Procedures With CC).

Using the methodology described in the September 7, 2001 final rule (66 FR 46918), we calculated a case-weighted threshold based on the distribution of these 82 cases across 23 DRGs. In order to qualify for new technology payments based on these DRGs, the threshold would be $82,882 (compared to the average standardized charge of $86,184 noted above).

In the September 7, 2001 final rule, we stated that the data submitted must be of a sufficient sample size to demonstrate a significant likelihood that the sample mean approximates the true mean across all cases likely to receive the new technology. Using a standard statistical methodology for determining the needed (random) sample size based on the standard deviations of the DRGs identified in the trial as likely to include cases receiving Xigris ™, we have determined that a random sample of 274 cases can be reasonably expected to produce an estimate within $3,500 of the true mean.[1] Of course, the data

[1] The formula is $n = 4\sigma^2/\beta^2$, where σ is the standard deviation of the population, and β is the

submitted do not represent a random sample.

The 274 case sample was for all U.S. patients over age 65 included in the PROWESS trial. In the September 7, 2001 final rule, we indicated our preference for using Medicare cases identifiable in our MedPAR database, although data from a trial without matching MedPAR data could be considered. We also indicated our intention to independently verify the data submitted.

According to Lilly, the patient consent agreements for the PROWESS trial did not provide for the collection and submission of data to CMS. Therefore, we have been unable to identify matching cases in our MedPAR database, or independently verify the data. Due to the passage of Public Law 106–554 in December 2000 and the publication of the final rule in September 2001, it is understandable that our data requirements in order to analyze applicants for new technology add-on payments were not accommodated in the design of the PROWESS trial. We will continue to work with Lilly to independently verify the data in the event it is determined that Xigris™ does represent a substantial clinical improvement.

In particular, we note that, even without the biological charges, the standardized mean charge for the cases submitted for analysis is well above the standardized case-weighted DRG mean ($70,623 for the PROWESS trial cases compared to $54,058 for all cases in the relevant DRGs). We are analyzing our MedPAR data to develop a cohort group of patients to assess the validity of the charges reported for the patients in the PROWESS trial and will report the result of our analysis in the final rule. We solicit comments on this and other approaches to verifying these data.

Cases where Xigris™ is administered will be identified by use of the new ICD–9–CM procedure code 00.11 (Infusion of drotrecogin alfa (activated)). According to Lilly, ''(t)he net wholesale price for drotrecogin alfa (activated) is $210 for a 5-milligram vial and $840 for a 20-milligram vial. The average cost for a one-time 96-hour course of therapy for an average adult patient is $6,800 (24 ug/kg/hr for 96 hours for a 70 kg person).'' Because code 00.11 does not identify the actual amount of the drug administered per patient, any additional payment would be based on the average cost per patient of $6,800. If this technology were to be approved for add-on payment under § 412.88, cases involving the administration of Xigris™ would be eligible for additional payments of up to $3,400 (50 percent of the average cost of the drug).

For purposes of budget neutrality, we need to estimate the additional payments that would be made under this provision during FY 2003. Lilly has estimated that, initially, 25,000 Medicare patients would receive drotrecogin alfa (activated). If the maximum $3,400 add-on payment is made for all 25,000 of these patients, the total amount that would be paid for these cases would be an additional $85 million. However, comparing the total standardized charges for the 274 patients age 65 or older, 56 percent had average standardized charges below the weighted average standardized charges for the 23 DRGs into which these cases were categorized. Therefore, assuming the costs for these cases would be below the payment received, these 56 percent of cases would not receive any additional payment. Therefore, for purposes of budget neutrality, we estimate the total payments likely to be made under this provision during FY 2003 for cases involving the administration of drotrecogin alfa (activated) would be $37.4 million (44 percent of $85 million).

b. Bone Morphogenetic Proteins (BMPs) for Spinal Fusions

BMPs have been isolated and shown to have the capacity to induce new bone formation. Using recombinant techniques, some BMPs (referred to as rhBMPs) can be produced in large quantities. This has cleared the way for their potential use in a variety of clinical applications such as in delayed unions and nonunions of fractured bones and spinal fusions. One such product, rhBMP–2, is developed for use instead of a bone graft with spinal fusions.

An application was submitted by Medtronic Sofamor Danek for the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for approval as a new technology eligible for add-on payments. The product is applied through use of an absorbable collagen sponge and an interbody fusion device, which is then implanted at the fusion site. The patient undergoes a spinal fusion, and the product is placed at the fusion site to promote bone growth. This is done in place of the more traditional use of autogenous iliac crest bone graft.

In 1997, in a pilot study conducted under a FDA approved device exemption, 14 patients were enrolled at 4 investigational sites. Eleven patients received rhBMP–2, with 3 control patients. Radiographs and computed tomography scans at 6, 12, and 24 months after surgery showed that all 11 patients who received rhBMP–2 had solid fusions, whereas only 2 of the 3 patients who received autogeneous bone graft had solid fusions. Scores from the Oswestry Low Back Pain Disability Questionnaire showed that 6 of 11 patients treated with rhBMP–2 had a successful outcome at 3 months after surgery, compared with 0 of 3 control patients. After 6 months, the results had changed to 7 of 11 rhBMP–2 patients and 2 control patients with successful treatments; and at 12 months, 10 rhBMP–2 patients and 2 control patients were judged successful. The results were unchanged at 24 months. The trial results were presented in an article in the February 1, 2000 edition of SPINE (Bone, S., Zdeblick, T., et. al., ''The Use of rhBMP–2 in Interbody Fusion Cages-Definitive Evidence of Osteoinduction in Humans: A Preliminary Report''), Vol. 25, No. 3, p. 376.

The above study was then expanded to involve 281 patients at 16 sites, with 143 patients in the rhBMP–2 group and 138 patients in the autogenous iliac crest bone graft group. In the rhBMP–2 group, 76.9 percent of the patients showed an improvement of at least 15 points in their disability scores at 12 months postoperatively. This compared favorably to 75 percent of patients in the control group. At 6 months following surgery, 97 percent of patients in the rhBMP–2 group showed evidence of interbody fusion, as compared to 95.8 percent in the control group. At 12 months, 96.9 percent of patients in the rhBMP–2 group were fused as compared to 92.5 percent in the control group. At this time, the results of this study are unpublished.

On January 10, 2002, the FDA issued an approvable letter for this technology. At this point, however, the technology has not been approved by the FDA for general use. Therefore, we are not proposing to approve this technology for add-on payments in this proposed rule. We discuss thoroughly the data submitted with the application below. However, if the FDA approves the product for general use prior to our issuance of the final rule by August 1, 2002, we will issue a determination whether this technology represents a substantial clinical improvement under the criteria outlined in the September 7, 2001 final rule.

Cost data were submitted for 88 patients participating in the followup study described above. This trial was a single-level, anterior lumbar interbody

bound on the error of the estimate (the range within which the sample means can reliably predict the population mean). See Statistics for Management and Economics, Fifth Edition, by Mendenhall, W., Reinmuth, J., Beaver, R., and Duhan, D.

fusion clinical study. Of these 88 bills with cost data, the applicant calculated an average standardized charge for these single-level fusion cases of $33,757. According to the applicant, ''it is anticipated that a large number, if not the majority, of cases using BMP technology will, in practice, be multi-level fusions''. The applicant reported the estimated hospital charges (based on general charging practices) to be $17,780 for each level. In order to account for the use of this technology in multilevel spinal fusions, the applicant assumed 47 percent of spinal fusions were multilevel (based on analysis of Medicare spinal fusion cases). Increasing the average standardized charge for the cases in the trial by $17,780, the applicant calculated a weighted average standardized charge (53 percent single-level and 47 percent multilevel) of $45,556.

Of these 88 cases, 11 were assigned to DRG 497 (Spinal Fusion Except Cervical With CC) and 77 were assigned to DRG 498 (Spinal Fusion Except Cervical Without CC). In order to qualify for new technology payments based on these DRGs, the threshold would be $37,815.

The applicant has submitted data that estimate between 2,300 and 4,600 Medicare spinal fusion procedures involving this technology in FY 2003. The cost of the technology is $3,900 per level. For approximately 45 percent of spinal fusion involving multilevel fusions, the weighted cost of the technology is $5,686, resulting in a maximum add-on payment amount of $2,843. In reference to the utilization estimates above, the total amount for these cases if each case qualified for a new technology payment would be between $6.5 million and $13.0 million.

c. Zyvox ™

Zyvox™ is the first antibiotic in the oxazolidinone class and is widely used by hospitals in the United States and other countries against the medically significant gram-positive bacteria, including those that are resistant to other therapies. Gram-positive bacterial infections have become increasingly prevalent in recent years, most commonly implicated in infections in the lower respiratory tract, skin and soft tissue, bone and bloodstream, and in meningitis. Significant morbidity and mortality trends are associated with such pathogens. Epinomics Research, Inc., submitted the application on behalf of Pharmacia Corporation (Pharmacia), which markets the drug.

The FDA approved Zyvox™ on April 18, 2000, for the treatment of serious infections caused by antibiotic-resistant bacteria. The applicant contends that this qualifies Zyvox™ for approval within the 2-year to 3-year period referenced at § 412.87(b)(2). Furthermore, the applicant notes that the approval of the new ICD–9–CM code 00.14 (Injection or infusion of oxazolidinone class of antibiotics) effective October 1, 2002, will permit a more precise identification of these cases. However, as noted previously, technology will no longer be considered new after the costs of the technology are reflected in the DRG weights. Because the costs of Zyvox™ are currently reflected in the DRG weights, Zyvox™ does not meet our criterion that a medical service or technology be ''new''. The FY 2001 MedPAR data used to calculate the proposed DRG weights for FY 2003 include cases where Zyvox™ was administered. The application itself noted that the use of Zyvox™ is widespread. Therefore, even though the existing code, 99.21 (Injection of antibiotic) is a general code used for the administration of various antibiotics including Zyvox™, and does not separately identify the administration of Zyvox™ as will be possible with the new code 00.14, the charges associated with these cases are reflected in the proposed FY 2003 DRG weights.

As stated above, we note that the applicant itself points out that Zyvox™ is widely used currently by hospitals. In its 4th quarter 2001 earnings report, Pharmacia reports total sales in the United States of $97 million, which is an increase of 105 percent over the previous year. This would indicate expanding access to the drug.

We would point out that, in response to a comment that technologies should qualify as ''new'' beginning with the assignment of an appropriate tracking code, we clarified in the September 7, 2001 final rule that we would not consider technologies that have been on the market for more than 2 or 3 years to be ''new'' on the basis that a more precise ICD–9-CM procedure code has been created (66 FR 46914). However, although such technologies would not qualify for add-on payments under this provision, we did indicate that we would evaluate whether the existing DRG assignments of the technology are appropriate.

For example, currently the administration of Zyvox ™ does not affect the DRG to which a case is assigned. In its application for add-on payments, Epinomics provided CMS data that included clinical trials as well as data from a sample that spanned MedPAR files from FY 2000 through FY 2002. For its sample study, Epinomics obtained patient records from 70 hospitals that used Zyvox™ treatment on 832 Medicare patients. The cases were distributed across 151 DRGs. Epinomics calculated that the mean standardized charge for these 485 cases was $74,174. The case-weighted mean standardized charge for all cases in these DRGs would be $33,740 (based on the distribution of Zyvox™ cases across the 151 DRGs).

The unit price for the drug varies from approximately $30 for a 100 milliliter bag (200 milligram linezolid) to approximately $1,350 for 600 milligram tablets (unit doses of 30 tablets). Nevertheless, it appears the high average charges associated with patients receiving the drug are not directly attributable to the administration of Zyvox™. Therefore, we are not proposing any changes to the DRG assignment of these cases at this time. To the extent these cases are more expensive due to the severity of illness of the patients being treated, the current outlier policy will offset any extraordinarily high costs incurred.

d. Renew™ Radio Frequency Spinal Cord Stimulation Therapy

An application was submitted by Advanced Neuromodulation Systems (ANS) for the Renew™ Spinal Cord Stimulation Therapy for approval as a new technology eligible for add-on payments. ANS is a medical device company that deals with management of chronic pain that is severe, persistent, and unresponsive to drugs or surgery. Spinal cord stimulation (SCS) offers a treatment alternative to expensive ongoing comprehensive care. Renew™ SCS was introduced in July 1999 as a device for the treatment of chronic intractable pain of the trunk and limbs.

According to the applicant:

''SCS is a reversible method of pain control that works well for certain types of chronic intractable pain. SCS requires a surgical procedure to implant a receiver and leads. These implanted devices generate electrical stimulation that interrupts pain signals to the brain. SCS is considered to be a treatment of last resort, and is usually undertaken only when first and second-line therapies for chronic pain fail to provide adequate relief. SCS uses low-intensity electrical impulses to trigger nerve fibers selectively along the spinal cord. The stimulation of these nerve fibers diminishes or blocks the intensity of the pain message being transmitted to the brain. SCS replaces areas of intense pain with a more pleasant sensation * * *,'' masking the pain that is normally present.

Prior to Renew™, SCS systems offered few technical capabilities for treating complex chronic pain patients who suffered with pain that spanned

noncontiguous areas (multi-focal) or that varied in intensity over the painful area. The Renew™ system features a multiplex output mode that controls separate stimulation programs to allow outputs of varying frequencies to be used at the same time. According to ANS, ''The significance of this technology is that it is now possible to multiplex (link and cycle) up to 8 programs to provide pain relieving paresthesia overlap of anatomical regions that are not contiguous or that cannot be captured by a single program.''

The Renew™ technology also allows the concomitant use of separate programs for patients who require different power settings for different areas that have pain. With this technology, separate programs can be programmed from the same unit, with electrical output parameters customized for each painful region. ANS contends that the clinical significance of this technology is that patients who find satisfactory pain relief will require fewer alternative treatments to treat unrelieved pain.

The ANS application specifically requests add-on payments for the costs of the Radio Frequency System (RF System). This system only requires one surgical placement and does not require additional surgeries to replace batteries as do other internal SCS systems. ANS estimates that there are 2,900 RF Systems implanted annually; only 10 percent are in the inpatient setting. ANS is the only company that offers a 16-channel/electrode system.

ANS provided the 2001 hospital acquisition cost for ANS Renew™ 8 and 16 Channel/Electrode RF SCS Systems as follows:

	ANS 2001 List Price
8 Channel/Electrode System:	
One Lead (8 Electrode)	$2,750
One Extension (8 Electrode)	695
Receiver (8 Channel)	4,995
Transmitter (8 Channel)	4,995
Total System	13,435
16 Channel/Electrode System:	
Two Leads (16 Electrodes)	5,500
Two Extensions (16 Electrodes)	1,390
Receiver (16 Channel)	7,295
Transmitter (16 Channel)	7,295
Total System	21,480

Currently, implanting the ANS 8 or 16 Channel/Electrode SCS System falls into DRG 4 (Spinal Procedures) under ICD–9–CM procedure code, 03.93 (Insertion or replacement, spinal neurostimulation). According to the September 7, 2001 **Federal Register**, the threshold to qualify for additional new technology payments for services classified to DRG 4 would be $38,242 (based on adding the geometric mean and the standard deviation of standardized charges) (66 FR 46922).

Relative to hospital invoice information, ANS provided the following estimates:

''* * * 90% of the U.S. hospital cost-to-charge ratios fall between .24 and .69, and 75% fall between .29 and .58. The median is .41. This median costs-to-charge ratio equates to an average hospital markup of 144%. If you apply the average hospital markup of 144% to the device acquisition cost plus the estimated facility cost, the result is an estimated hospital invoice for the SCS implant procedure of $40,101.00, for the 8 Channel/Electrode System and $59,731.00 for the 16 Channel/Electrode System.''

In support of its application, ANS provided detailed bills for 12 patients. Of the 12 cases with detailed billing data, 3 patients were age 65 or older. The average total charge for these 3 cases, including the average standardized charge for operating room costs, was $42,820.

As noted previously, technology will no longer be considered new after the costs of the technology are reflected in the DRG weights. Because the Renew ™ RF System was introduced in July 1999, the FY 2001 MedPAR data used to calculate the proposed DRG weights for FY 2003 includes any Medicare cases that involved the implantation of the Renew™ RF System. The charges associated with these cases are reflected in the proposed FY 2003 DRG weights. Therefore, the Renew™ RF System is not considered ''new'' under our criteria. However, we will continue to monitor these cases in DRG 4 to determine whether this is the most appropriate DRG assignment.

III. Proposed Changes to the Hospital Wage Index

A. Background

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

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

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

In a December 27, 2000 notice published in the **Federal Register** (65 FR 82228), OMB issued its revised standards for defining MSAs. In that notice, OMB indicated that it plans to announce in calendar year 2003 definitions of MSAs based on the new standards and the Census 2000 data. We will evaluate the new area designations and their possible effects on the

Medicare wage index, as well as other provider payment implications. Although the final construct of the redefined MSAs will not be known until 2003, we intend to work closely with OMB to begin to assess the potential ramifications of these changes.

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

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to 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 (the FY 2005 wage index).

In the May 4, 2001 proposed rule (66 FR 22674), we suggested possible occupational categories from the Occupational Employment Statistics (OES) survey conducted by the Bureau of Labor Statistics. In response to comments on the proposed rule, we agreed to work with the health care industry to develop a workable data collection tool. After we develop a method that appropriately balances the need to collect accurate and reliable data with the need to collect data that 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.

B. Proposed FY 2003 Wage Index Update

The proposed FY 2003 wage index values in section V. of the Addendum to this proposed rule (effective for hospital discharges occurring on or after October 1, 2002 and before October 1, 2003) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1999 (the FY 2002 wage index was based on FY 1998 wage data).

The proposed FY 2003 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 2002 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 2002, the proposed wage index for FY 2003 also continues to exclude the direct and overhead salaries and hours for services such as skilled nursing facility (SNF) services, home health services, and other subprovider components that are not paid under the hospital inpatient 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 2003 Wage Index Proposal

1. Removal of Wage Costs and Hours Related to Graduate Medical Education (GME) and Certified Registered Nurse Anesthetists (CRNAs)

Because the hospital wage index is used to adjust payments to hospitals under the acute care hospital inpatient prospective payment system, the wage index should, to the extent possible, reflect the wage costs associated with those cost centers and units paid under the hospital inpatient prospective payment system. Costs related to graduate medical education (GME) (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs) are paid by Medicare separately from the hospital inpatient prospective payment system. In 1998, the AHA convened a workgroup to develop a consensus recommendation on this issue. The workgroup, which consisted of representatives from national and State hospital associations, 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.

FY 2003 would be the fourth year of the phaseout. Therefore, the wage index calculation for FY 2003 would blend 20 percent of a wage index with GME and CRNA costs included and 80 percent of a wage index with GME and CRNA costs removed. FY 2004 would begin the calculation with 100 percent of the GME and CRNA costs removed. However, we are proposing to remove 100 percent of GME and CRNA costs from the FY 2003 wage index, as discussed below.

We have analyzed the FY 2003 wage index both with 100 percent of GME and CRNA costs removed and with 80 percent of these costs removed. We found that the majority of labor market areas, both rural and urban, would benefit by the removal of all of these costs (298 out of 373). Only two rural labor market areas would be negatively impacted by this change (Pennsylvania by −0.01 percent, and New Hampshire by −0.12 percent). We note that, as part of its Report to the Congress on Medicare in Rural America (June 2001), the MedPAC recommended fully implementing this phaseout during FY 2002. Similar to our findings, MedPAC found the effect of completely eliminating GME and CRNA costs ''might not be negligible for some areas, but it would not be large in any case'' (page 76). Of the urban labor market areas that would be negatively affected, the impacts on all but two areas are less than 0.50 percent, and the largest negative impact is 1.12 percent.

Because we believe removing GME and CRNA costs from the wage index calculation is appropriate, and the impact is generally positive and relatively small, we are proposing to remove 100 percent of GME and CRNA costs beginning with FY 2003 wage index.

2. Contract Labor for Indirect Patient Care Services

Our policy concerning the inclusion of contract labor costs for purposes of calculating the wage index has evolved with the increasing 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 for direct patient care contract services in the

wage index calculation, and with the FY 1999 wage index, we included the costs for certain management contract services. (The August 30, 1996 final rule (61 FR 46181) provided an in-depth discussion of the issues related to the inclusion of contract labor costs in the wage index calculation.) Further, the FY 1999 wage index included the costs for contract physician Part A services, and the FY 2002 wage index included the costs for contract pharmacy and laboratory services.

We continue to consider whether to expand our contract labor definition to include more types of contract services in the wage index. In particular, we have examined whether to include the costs for acquired dietary and housekeeping services, as many hospitals now provide these services through contracts. Costs for these services tend to be below the average wages for all hospital employees. Therefore, excluding the costs and hours for these services if they are provided under contract, while including them if the services are provided directly by the hospital, creates an incentive for hospitals to contract for these services in order to increase their average hourly wage for wage index purposes.

It has also been suggested that we expand our definition to include all contract services, including both direct and indirect patient care services, in order to more appropriately calculate relative hospital wage costs. Our goal is to ensure that our wage index policy continues to be responsive to the changing need for contract labor and allow those hospitals that must depend on contract labor to supply needed services to reflect those costs in their wage data. At the same time, we are concerned about hospitals' ability to provide documentation that sufficiently details contract costs and hours. The added overhead, supplies, and miscellaneous costs typically associated with contract labor may result in higher costs for contract labor compared to salaried labor. If these costs are not separately identifiable and removed, they may cause distortions in the wage index.

We agree that it may be appropriate to include indirect patient care contract labor costs in the wage index. However, in light of concerns about hospitals' ability to accurately document and report these costs, we believe the best approach is to assess and include these costs incrementally. Through incremental changes, we can better determine the impact that specific costs have on area wage index values. Also, by including these costs incrementally, hospitals and fiscal intermediaries are able to adjust to the additional documentation and review requirements associated with reporting the additional contract costs and hours.

In this proposed rule, we are proposing to begin collecting contract labor costs and hours for management services and the following overhead services: administrative and general, housekeeping, and dietary. We selected these three overhead services because they are provided at all hospitals, either directly or through contracts, and together they comprise about 60 percent of a hospital's overhead hours. In addition, consistent with our consideration of administrative and general services, we propose to collect costs and hours associated with contract management services that are not currently included on Worksheet S–3, Part II, Line 9 (that is, management services other than those of the chief executive officer, chief financial officer, chief operating officer, and nurse administrator).

We propose to revise the FY 2002 Medicare cost report (or the next available cost report) to provide for the separate reporting of contract management, administrative and general, housekeeping, and dietary costs and hours. After evaluating these data, we will determine the feasibility of adding these categories of contract labor to the wage index calculation.

D. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 2003 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1999 Medicare cost reports. The data file used to construct the wage index includes FY 1999 data submitted to us as of February 15, 2002. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2003 wage index, pending their resolution before calculation of the final FY 2003 wage index. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data no later than April 5, 2002. We expect that all unresolved data elements will be resolved by that date. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed data for 96 hospitals that failed edits. For 6 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, are under new ownership and the data cannot be verified, or are in bankruptcy status. We identified 90 hospitals with incomplete or inaccurate data resulting in zero or negative average hourly wages. Therefore, they were removed from the calculation. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2003 wage index is calculated based on FY 1999 wage data for 4,718 hospitals.

E. Computation of the Proposed FY 2003 Wage Index

The method used to compute the proposed FY 2003 wage index follows.

Step 1—As noted above, we based the proposed FY 2003 wage index on wage data reported on the FY 1999 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, 1998 and before October 1, 1999. In addition, we included data from some hospitals that had cost reporting periods beginning before October 1998 and reported a cost reporting period covering all of FY 1999. 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 1999 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1999 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999), 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—Beginning with the FY 2003 wage index, the method used to compute a hospital's average hourly wage excludes all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on lines 2, 4.01, and 6, the Part B salaries

reported on Lines 3 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 SNF services, home health services, and other subprovider components not subject to the acute care hospital inpatient prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Line 4. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9, 9.01, 9.02, and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

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

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

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

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1998 through April 15, 2000 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
10/14/98	11/15/98	1.04550
11/14/98	12/15/98	1.04325
12/14/98	01/15/99	1.04111
01/14/99	02/15/99	1.03880
02/14/99	03/15/99	1.03632
03/14/99	04/15/99	1.03369
04/14/99	05/15/99	1.03092
05/14/99	06/15/99	1.02801
06/14/99	07/15/99	1.02509
07/14/99	08/15/99	1.02230
08/14/99	09/15/99	1.01962
09/14/99	10/15/99	1.01687
10/14/99	11/15/99	1.01385
11/14/99	12/15/99	1.01056
12/14/99	01/15/2000	1.00710
01/14/2000	02/15/2000	1.00358
02/14/2000	03/15/2000	1.00000
03/14/2000	04/15/2000	0.99638

For example, the midpoint of a cost reporting period beginning January 1, 1999 and ending December 31, 1999 is June 30, 1999. An adjustment factor of 1.02509 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 1999 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $22.9949.

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 $10.8935 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 of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2003, this change affects 163 hospitals in 40 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

F. Revisions to the Wage Index Based on Hospital Redesignation

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. Hospitals can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as rural groups. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Hospitals must apply for reclassification to the MGCRB, which issues its decisions by the end of February for reclassification to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are in §§ 412.230 through 412.280.

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

Section 304(b) of Public Law 106–554 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.

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the MSA to which the greatest number of workers in the county commute, 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 area) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that 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.

Section 402 of Public Law 106–113 provided that, for FYs 2001 and 2002, hospitals could elect whether to apply standards developed by OMB in 1980 or 1990 in order to qualify for redesignation under section 1886(d)(8)(B) of the Act. However, we are proposing that, beginning with FY 2003, redesignation under section 1886(d)(8)(B) of the Act will be based on the standards published in the **Federal Register** by the Director of OMB based on the most recent decennial census.

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.

• The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.

The proposed wage index values for FY 2003 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

Tables 3A and 3B in the Addendum of this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FY 1997, 1998, and 1999 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 proposed rule includes the adjusted average hourly wage for each hospital from the FY 1997 and FY 1998 cost reporting periods, as well as the FY 1999 period used to calculate the FY 2003 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously under computation of the proposed FY 2003 wage index) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2003 reclassification requests. We have included in this proposed rule a new Table 9, which shows hospitals that have been reclassified under either section 1886(d)(8)(B) or section 1886(d)(10)(D) of the Act. This table includes hospitals reclassified for FY 2003 by the MGCRB, as well as hospitals that were reclassified for the wage index in either FY 2001 or FY 2002 and are, therefore, in either the third or second year of their 3-year reclassification. There are 60 hospitals reclassified for the wage index beginning during FY 2003. In addition, 369 hospitals are reclassified for FY 2003 based on their 3-year reclassification that became effective during FY 2001, and 170 hospitals are reclassified for FY 2003 based on their 3-year reclassification that became effective during FY 2002. There are 124 hospitals included in the 3-year reclassification from FY 2001 that were reclassified in accordance with section 152(b) of Public Law 106–113. In addition, there are 38 rural hospitals redesignated to an urban area under section 1886(d)(8)(B) of the Act, and 14 urban hospitals that have been designated rural in accordance with section 1886(d)(8)(E) of the Act. Finally, there are 61 hospitals reclassified by the MGCRB for the standardized amount for FY 2003 (including one hospital that is also redesignated under section 1886(d)(8)(B) of the Act to a different MSA). The final number of reclassifications may vary because some MGCRB decisions are still under review by the Administrator and because some hospitals may withdraw their requests for reclassification.

Table 9 shows the various reclassifications and redesignations discussed above by individual hospital. The table does not reflect any hospital withdrawals from reclassifications approved by the MGCRB or decisions of the CMS Administrator. In the final rule to be published by August 1, 2002, we will include a similar table that will include all final reclassifications for FY 2003.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. In addition, hospitals may terminate an existing 3-year reclassification within 45 days of the publication of this proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2003 must be received by the MGCRB by June 24, 2002. A hospital that withdraws its application or terminates an existing 3-year reclassification may not later request reinstatement of the MGCRB decision, except by canceling such a withdrawal or termination in a subsequent year (see § 412.273(b)(2)(i), and the proposed changes and clarifications to the cancellation procedures in section V. of this preamble).

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule following this proposed rule. 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.

We are proposing limited changes and clarifications to the policies related to withdrawals, terminations, and cancellations of the 3-year wage index reclassifications. These are discussed in section V. of this preamble.

3. OMB Standards for Hospitals To Qualify for Redesignation

In the August 1, 2001 final rule, we implemented section 402 of Public Law 106–113. Section 402 provided that hospitals could elect whether to apply standards developed by OMB in 1980 or 1990 in order to qualify for redesignation under section 1886(d)(8)(B) of the Act. However, section 402 also states 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.

At this time, the 1990 standards are the most recent available. Although OMB is working to develop updated standards based on the 2000 census, that work is not yet completed. If the 2000 census population data become available prior to the preparation and publication of the final rule by August 1, 2002, CMS will work with the Population Distribution Branch within the Population Division of the U.S. Census Bureau to compile a list of hospitals that meet the established standards using the 2000 census population data. Otherwise, for purposes of redesignation for FY 2003 under section 1886(d)(8)(B) of the Act, qualifying hospitals must be located in counties meeting the 1990 standards.

In the August 1, 2001 final rule, we determined that three counties that qualified for redesignation under the 1980 standards qualified for redesignation to a different MSA using the 1990 standards (66 FR 39869). These counties, which will be redesignated to the MSA to which they qualify based on the 1990 standards, are as follows:

Rural county	1980 MSA designation	1990 MSA designation
Ionia, MI	Lansing-East Lansing, MI	Grand Rapids-Muskegon-Hollan, 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 allowed hospitals to elect to use either the January 3, 1980 standards or March 30, 1990 standards for payments during FY 2001 and FY 2002. Several hospitals in counties that did not qualify under the January 3, 1980 standards elected to use those older standards so they would not receive the urban designation accorded them under section 402 because they would lose their special rural designation (that is, a sole community hospital (SCH) or Medicare-dependent hospital (MDH)). Under section 402, the option to make such an election was available only for FY 2001 and FY 2002. Effective for FY 2003, we are proposing that hospitals located in counties qualifying for redesignation under section 1886(d)(8)(B) of the Act based on the 1990 standards would be redesignated under this provision.

We also noted in the August 1, 2001 final rule that five rural counties no longer meet the qualifying criteria when we apply the 1990 OMB standards (66 FR 39870). These rural counties are as follows: Indian River, FL; Mason, IL; Owen, IN; Morrow, OH; and Lincoln, WV. Therefore, beginning FY 2003, hospitals in these counties will not be eligible for redesignation unless the counties again qualify when the standards based on the 2000 census data are available.

G. Requests for Wage Data Corrections

As stated in section II.D. of this preamble, the data used to construct the proposed wage index includes FY 1999 data submitted to CMS as of February 15, 2002. In a memorandum dated December 19, 2001, we instructed all Medicare intermediaries to inform the prospective payment hospitals they service of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available on January 12, 2002, through the Internet at CMS's home page (*http://www.hcfa.gov*). We also instructed the intermediaries to advise hospitals of the availability of these data either through their representative hospital organizations or directly from CMS. Additional details on ordering this data file are discussed in section IX.A. of this preamble, ''Requests for Data from the Public.''

In addition, Table 2 in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the proposed wage index values for the past 3 years, including the FY 1999 data used to construct the proposed FY 2003 wage index. It should be noted that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS prior to February 15, 2002. Changes approved by a hospital's fiscal intermediary and forwarded to CMS by April 5, 2002, will be reflected in the final public use wage data file scheduled to be made available on or about May 10, 2002.

We believe hospitals have sufficient time to ensure the accuracy of their FY 1999 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. Hospitals should know what wage data were submitted on their cost reports. In addition, they are notified of any changes to their data as a result of their fiscal intermediary's review. However, if a hospital believed that its FY 1999 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by February 8, 2002. Hospitals were notified of this deadline, and of all other possible deadlines and requirements, through the December 19, 2001 memorandum referenced above.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any revised cost reports to CMS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a hospital disagrees with the fiscal intermediary's resolution of a policy issue (whether a general category of cost is allowable in the wage data), the hospital may contact CMS in an effort to resolve policy disputes. We note that the April 5, 2002 deadline also applies to these requested changes. During this review, we will not consider issues such as the adequacy of a hospital's supporting documentation, as these types of issues should have been resolved earlier in the process.

These deadlines are necessary to allow sufficient time to review and process the data so that the final wage index calculation can be completed for development of the final FY 2003 prospective payment rates to be published by August 1, 2002.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2003 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to later challenge, before the Provider Reimbursement Review Board, CMS'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)).

The final wage data public use file will be released on approximately May 10, 2002. Hospitals should examine both Table 2 of this proposed rule and the May 2002 final public use wage data file (which reflects revisions to the data used to calculate the values in Table 2) to verify the data CMS is using to calculate the wage index.

As with the file made available in January 2002, CMS will make the final wage data file released in May 2002 available to hospital associations and the public on the Internet. However, the May 2002 public use file will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (with the February 8 deadline). Hospitals are encouraged to review their hospital wage data promptly after the release of the May 2002 file. Data presented at this time cannot be used by hospitals to initiate new wage data correction requests.

If, after reviewing the final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and CMS. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be *received* by CMS and the fiscal intermediaries no later than June 7, 2002. Requests mailed to CMS should be sent to: Center for Medicare & Medicaid Services, Center for Health Plans and Providers, Attention: Wage Index Team, Division of Acute Care, C4–07–05, 7500 Security Boulevard, Baltimore, MD 21244–1850. Each request must also be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, between release of the May 2002 wage index file and June 7, 2002, changes to the hospital wage data will only be made in those very limited situations involving an error by the intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor CMS will accept the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 5, 2002.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2002 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 2002) will be incorporated into the final wage index to be published by August 1, 2002 and effective October 1, 2002.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals will have access to the final wage data by May 2002, they will have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2003 wage index by August 1, 2002, and the implementation of the FY 2003 wage index on October 1, 2002. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(x)(2) of our existing regulations, we make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or CMS 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 2003 (that is, by the June 7, 2002 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the fiscal intermediary will notify the hospital of any changes, we do not expect that midyear corrections would be necessary. However, if the correction of a data error changes the wage index value for an area, the revised wage index value is effective prospectively from the date the correction is approved.

This policy for applying prospective corrections to the wage index was originally set forth in the preamble to the January 3, 1984 final rule (49 FR 258) implementing the hospital inpatient prospective payment system. It has been our longstanding policy to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis.

Section 412.63(x)(3) states that revisions to the wage index resulting from midyear corrections to the wage index values are incorporated in the wage index values for other areas at the beginning of the next Federal fiscal year. Prior to October 1, 1993, the wage index was based on a wage data survey submitted by all hospitals (prior to that, the data came from the Bureau of Labor Statistics' hospital wage and employment data file). Beginning October 1, 1993, as required by section 1886(d)(3)(E) of the Act, we began updating the wage index data on an annual basis. Because the wage index has been updated annually since FY 1994, § 412.63(x)(3) is no longer necessary, and we are proposing to delete it. Similarly, § 412.63(x)(4) provides that the effect on program payments of midyear corrections to the wage index values is taken into account in establishing the standardized amounts for the following year. Again, the wage data are now updated annually. Therefore, § 412.63(x)(4) is no longer necessary, and we are proposing to delete it as well.

Finally, we are proposing to revise § 412.63(x)(2) to clarify that CMS will make a midyear correction to the wage index for an area only if a hospital can show that the intermediary or CMS made an error in tabulating the hospital's own data. That is, this provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index. As described above, the requesting hospital must show that it could not have known about the error, or that it did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

IV. Proposed Rebasing and Revision of the Hospital Market Baskets

A. Operating Costs

1. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital ''market basket'') for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchased in order to furnish inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to furnish hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the acute care hospital inpatient prospective payment system, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. For FY 2003, payment rates will be updated by the projected increase in the hospital market basket minus 0.55 percentage points. A detailed explanation of the hospital market basket used to develop the prospective payment rates was published in the **Federal Register** on September 3, 1986 (51 FR 31461). We also refer the reader to the August 29, 1997 **Federal Register** (62 FR 45966) in

which we discussed the previous rebasing of the hospital input price index.

The hospital market basket is a fixed-weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. These price proxies are price levels derived from publicly available statistical series and are published on a consistent schedule, preferably at least on a quarterly basis.

Finally, the expenditure weight for each category is multiplied by the level of the respective price proxy. The sum of these products (that is, the expenditure weights multiplied by the price levels) for all cost categories yields the composite index level of the market basket in a given year. Repeating this step for other years produces a series of market basket index levels over time. Dividing one index level by an earlier index level produces rates of growth in the input price index over that time.

The market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed weight hospital market basket. In this manner, the index measures only the pure price change. Only rebasing (changing the base year) the index would capture these quantity and intensity effects. Therefore, we rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. We last rebased the hospital market basket cost weights in 1997, effective for FY 1998 (62 FR 45993). This market basket, still used through FY 2002, reflects base year data from FY 1992 in the construction of the cost weights.

We note that there are separate market baskets for acute care hospital inpatient prospective payment system hospitals and excluded hospitals and hospital units. In addition, we are in the process of conducting the necessary research to determine if separate market baskets for the inpatient rehabilitation, long-term care, and psychiatric hospital prospective payment systems can be developed. However, for the purpose of this preamble, we are only discussing the market basket based on all excluded hospitals together.

2. Rebasing and Revising the Hospital Market Basket

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, we are proposing to shift the base year cost structure from FY 1992 to FY 1997). Revising means changing data sources, cost categories, or price proxies used in the input price index.

We are proposing to use a rebased and revised hospital market basket in developing the FY 2003 update factor for the prospective payment rates. The new market basket would be rebased to reflect FY 1997, rather than FY 1992, cost data. The 1992-based market baskets contained expenditure data for hospitals from Medicare cost reports for cost reporting periods beginning on or after October 1, 1991, and before October 1, 1992. The 1997-based market baskets use data for hospitals from Medicare cost reports for cost reporting periods beginning on or after October 1, 1996, and before October 1, 1997. Fiscal year 1997 was selected as the new base year because 1997 is the most recent year for which relatively complete data are available. These include data from FY 1997 Medicare cost reports as well as 1997 data from two U.S. Department of Commerce publications: the Bureau of the Census' Business Expenditure Survey (BES) and the Bureau of Economic Analysis' Annual Input-Output Tables. In addition, preliminary analysis of FYs 1998 and 1999 Medicare cost report data showed little difference in cost shares from FY 1997 data.

In developing the proposed rebased and revised market baskets, we reviewed hospital operating expenditure data for the market basket cost categories in determining the cost weights. We relied primarily on Medicare hospital cost report data for the proposed rebasing. We prefer to use cost report data wherever possible because these are the cost data supplied directly from hospitals. Other data sources such as the BES and the input-output tables serve as secondary sources used to fill in where cost report data are not available or appear to be incomplete. Below we are providing a detailed discussion of the process for calculating cost share weights.

Cost category weights for the proposed FY 1997-based market baskets were developed in several stages. First, base weights for several of the categories (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals and Blood and Blood Products) were derived from the FY 1997 Medicare cost reports for operating costs. The expenditures for these categories were calculated as a percentage of total operating costs from those hospitals covered under the inpatient hospital prospective payment system. These data were then edited to remove outliers and ensure that the hospital participated in the Medicare program and had Medicare costs. However, we were unable to measure only those operating costs attributable to the inpatient portion of the hospital, because many cost centers are utilized by both inpatients and outpatients in the hospital. Health Economics Research (HER), under contract with CMS, is currently in the process of researching the possibility of constructing a separate outpatient market basket for CMS' outpatient hospital prospective payment system. This research may provide some insight and guidance for separating inpatient and outpatient costs. We excluded hospital-based subprovider cost centers (for example, skilled nursing, nursing, hospice, psychiatric, rehabilitation, intermediate care/mental retardation, and other long-term care) as well as the portion of overhead and ancillary costs incurred by these subproviders.

Second, the weight for professional liability insurance was calculated using data from a survey conducted by ANASYS under contract to CMS. This survey, called the National Hospital Malpractice Insurance Survey (NHMIS), was conducted to estimate hospital malpractice insurance costs over time at the national level. A more detailed description of this survey is found later in this preamble.

Third, data from the 1997 Business Expenditure Survey (BES) was used to develop a weight for the utilities and telephone services categories. Like most other data sources, the BES includes data for all hospitals and does not break out data by payer. However, we believe the overall data from the BES does not produce results that are inconsistent with the prospective payment system hospitals, particularly at the detailed

cost category level with which we are working.

Fourth, the sum of the weights for wages and salaries, employee benefits, contract labor, professional liability insurance, utilities, pharmaceuticals, blood and blood products, and telephone services was subtracted from other operating expenses to obtain a portion for all other expenses.

Finally, the remainder of the weight for all other expenses was divided into subcategories using relative cost shares from the 1997 Annual Input-Output Table for the hospital industry, produced by the Bureau of Economic Analysis, U.S. Department of Commerce. The 1997 Benchmark Input-Output data will be available, at the earliest, in late 2002, so we will be unable to incorporate these data in the final rule.

Below, we further describe the sources of the six main category weights and their subcategories in the proposed FY 1997-based market basket. We note the differences between the methodologies used to develop the FY 1992-based and the FY 1997-based market baskets.

- *Wages and Salaries:* The cost weight for the wages and salaries category was derived using Worksheet S–3 from the FY 1997 Medicare cost reports. Contract labor, which is also derived from the FY 1997 Medicare cost reports, is split between the wages and salaries and employee benefits cost categories, using the relationship for employed workers. An example of contract labor is registered nurses who are employed and paid by firms that contract for their work with the hospital. The wages and salaries category in the FY 1992-based market basket was developed from the FY 1992 Medicare cost reports. In addition, we used the 1992 Current Population Survey to break out more detailed occupational subcategories. These subcategories were not broken out for the proposed FY 1997-based market basket.
- *Employee Benefits:* The cost weight for the employee benefits category was derived from Worksheet S–3 of the FY 1997 Medicare cost reports. The employee benefits category in the FY 1992-based market basket was developed from FY 1992 Medicare cost reports and used the 1992 Current Population Survey to break out various occupational subcategories. These subcategories were not broken out for the proposed FY 1997-based market basket.
- *Nonmedical Professional Fees:* This category refers to various types of nonmedical professional fees such as legal, accounting, engineering and management and consulting fees. Management and consulting and legal fees make up the majority of professional fees in the hospital sector. The cost weight for the nonmedical professional fees category was derived from the Bureau of Economic Analysis Input-Output data for 1997. The FY 1992-based index used a combination of data from the American Hospital Association (AHA) and the Medicare cost reports to arrive at a weight. However, because the AHA survey data for professional fees are no longer published, we were unable to duplicate this method. Had we used the proposed methodology to calculate the FY 1992 nonmedical professional fees component, the proportion would have been similar to the FY 1997 share.
- *Professional Liability Insurance:* The proposed FY 1997-based market basket uses a weight for professional liability insurance derived from a survey conducted by ANASYS under contract to CMS (Contract Number 500–98–005). This survey attempted to estimate hospital malpractice insurance costs over time at the national level for years 1996 and 1997. The population universe of the survey was defined as all non-Federal short-term, acute care prospective payment system hospitals. A statistical sample of hospitals was drawn from this universe and data collected from those hospitals. This sample of hospitals was then matched to the appropriate cost report data so that a malpractice cost weight could be calculated. The questions used in the survey were based on a 1986 General Accounting Office (GAO) malpractice survey questionnaire that was modified so data could be collected to calculate a malpractice cost weight and the rate of change for a constant level of malpractice coverage at a national level. The 1997 proportion as calculated by ANASYS was compared to limited data for FYs 1998 and 1999 contained in the Medicare Health Care System Cost Report Information System (HCRIS). The percentages are relatively comparable. However, since this field was virtually incomplete in the FY 1997 cost report file, we were unable to use this cost report data.

  In contrast, the FY 1992-based market basket professional liability insurance weight was determined using the cost report data for PPS–6 (cost reporting periods beginning in FY 1989), the last year these costs had to be treated separately from all other administrative and general costs, trended forward to FY 1992 based on the relative importance of malpractice costs found in the previous market basket.
- *Utilities:* For the proposed FY 1997-based market baskets, the cost weight for utilities was derived from the Bureau of the Census' Business Expenditures Survey. For the FY 1992-based market baskets, the cost weight for utilities was derived from the Bureau of the Census' Asset and Expenditures Survey. The Business Expenditure Survey replaced the Asset and Expenditure Survey and the categories and results are similar.
- *All Other Products and Services:* The all other products and services category includes the remainder of products and services that hospitals purchase in providing care. Products found in this category include: direct service food, contract service food, pharmaceuticals, blood and blood products, chemicals, medical instruments, photo supplies, rubber and plastics, paper products, apparel, machinery and equipment, and miscellaneous products. Services found in this category include: telephone, postage, other labor-intensive services, and other nonlabor-intensive services. Labor-intensive services include those services for which local labor markets would likely influence prices. A complete discussion of the labor-related share is presented later in this preamble. The shares for pharmaceuticals and blood and blood products were derived from the FY 1997 Medicare cost reports, while the share for telephone services was derived from the BES. Relative shares for the other subcategories were derived from the 1997 Bureau of Economic Analysis Annual Input-Output Table for the hospital industry.

  The calculation of these subcategories involved calculating a residual from the Input/Output Table using categories similar to those not yet accounted for in the market basket. Subcategory weights were then calculated as a proportion of this residual and applied to the similar residual in the market basket.
- *Blood and blood products:* When the market basket was last revised and rebased to FY 1992, the component for blood services was discontinued because of the lack of appropriate data to determine a weight. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required that CMS consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in the market basket. In accordance with this requirement, CMS has done considerable research to determine if a component for blood and blood products should be added to the market basket and, if so, how the weight should be determined. CMS has studied four alternative data sources to possibly

determine a weight for blood in the market basket. If none of these data sources was deemed acceptable, we could conclude that a component for blood should not be reintroduced in the hospital market basket. In a December 2001 report by the MedPAC entitled ''Blood Safety in Hospitals and Medicare Inpatient Payment,'' MedPAC recommended that the market basket should explicitly account for the cost of blood and blood products by reintroducing a separate component for their prices.

The first alternative data source studied was using data from the Medicare cost reports. The cost reports have two cost centers where the costs of blood can be recorded: (1) whole blood and packed red blood cells (nonsalary); and (2) blood storing, processing, and transfusion (nonsalary). Although all prospective payment system hospitals submit a cost report, less than half of these hospitals reported data in either of the two blood cost centers. However, if we can determine that the hospitals reporting blood are representative of all prospective payment system hospitals, then a cost share can be computed using the cost reports.

The second alternative involves constructing weights from the Input-Output Table from the BEA, Department of Commerce. These data were used to construct the weight when the market basket was revised before FY 1992. Unfortunately, BEA stopped reporting blood separately in their Input-Output Table in 1987. One possible use of these data would be to calculate a weight by updating the prior weight by the relative price change for blood between the last data point available and 1997. However, by using this method, only the escalation in prices, not the changes in quantity or intensity of use of blood products, would be captured.

The third alternative was using data from the MedPAR files. This option was discussed in MedPAC's December 2001 report, and involves using claims data or data on hospital charges. In order to construct a weight for the market basket, the underlying costs of blood must be calculated from the claims data. An analysis of cost-to-charge ratios of hospitals can determine if this is feasible.

The final alternative data source is the Bureau of the Census' quinquennial Business Expenditure Survey and the Economic Census. A weight can be obtained indirectly by taking the ratio of receipts of nonprofit blood collectors to total operating expenses of hospitals. Some adjustments would be needed in order for the weight calculated in this way to be completely valid. In addition, this method assumes that all blood used by hospitals comes from nonprofit sources. However, in 1999, hospitals collected 7 percent of the donated units.

After a thorough analysis, CMS has determined that the Medicare cost reports, after minor adjustments, are the best option. The data from the Input-Output Table are not optimal because they are not current and would have to be aged using only price data, which do not reflect quantity and intensity changes over this period. Although the MedPAR data could be adjusted to compute a cost share, using claims data is not the preferred alternative. Census data would be an attractive option if the cost reports were not available.

The main weakness of the Medicare cost reports is the inconsistent reporting of hospitals in the two blood cost centers. In 1997, only 48.0 percent of all hospitals reported blood in one or both cost centers. However, these hospitals accounted for 62.2 percent of the operating costs of all hospitals. In order for the calculation of the blood cost share weight to be acceptable, the hospitals that reported blood would need to be adjusted to be representative of all hospitals, including those that did not report blood on the cost reports.

Because of the similarity of data in the two blood cost centers, the assumption was made that if a hospital reported blood in only one of the two cost centers, all of its blood costs were reported in that cost center. In the FY 1997 cost reports, of the hospitals that reported blood, 41.3 percent reported only in the blood cells cost center, 58.2 percent reported only in the blood storing cost center, and only 0.5 percent reported in both blood cost centers. To calculate a weight, the numerator was the summation of the data in both blood cost centers. The denominator was the summation of the operating costs of each hospital that reported blood in each cost center minus the operating costs of the few hospitals that reported blood in both cost centers to avoid double counting.

The blood cost share calculated from these data was then adjusted so that the hospitals reporting blood had the same characteristics of all other hospitals. Adjustments were necessary because the hospitals that reported blood were more likely to be urban and teaching hospitals than those hospitals that did not report blood. The adjustments made less than a 0.1 percent difference in the cost share.

The weight produced using the cost report for FY 1997 was 0.875 percent. We also looked at cost report data from FYs 1996 and 1998. The weights calculated in these years were similar to the FY 1997 weight. The calculation of the blood cost share using the alternative data sources cited above was similar to the results using the cost reports. Given the consistency with these other sources, the representativeness of our estimate, and the stability of the cost share, we are proposing to use the Medicare cost reports to determine a weight for blood and blood products in the proposed hospital market basket.

Overall, our work resulted in the identification of 23 separate cost categories that represent the rebased weights in the proposed rebased and revised hospital market basket. There is one more category than was included in the FY 1992-based market basket (FY 1992-based had 22). The differences between the weights of the major categories determined from the Medicare cost reports for the proposed FY 1997-based index and the previous FY 1992-based index are summarized in Table 1.

TABLE 1.—FY 1992-BASED AND PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING MAJOR COST CATEGORIES AND WEIGHTS AS DETERMINED FROM THE MEDICARE COST REPORTS

Expense categories	Proposed rebased FY 1997 hospital market basket	FY 1992-based hospital market basket
Wages and Salaries	50.686	50.244
Employee Benefits	10.970	11.146
Pharmaceuticals	5.416	4.162
Blood and Blood Products	0.875	.....

TABLE 1.—FY 1992-BASED AND PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING MAJOR COST CATEGORIES AND WEIGHTS AS DETERMINED FROM THE MEDICARE COST REPORTS—Continued

Expense categories	Proposed rebased FY 1997 hospital market basket	FY 1992-based hospital market basket
All Other	32.053	34.448
Total	100.000	100.000

Table 2 sets forth all of the proposed market basket cost categories and weights. For comparison purposes, the 1992-based cost categories and weights are included in the table.

TABLE 2.—FY 1992-BASED AND PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS

Expense categories	Proposed rebased FY 1997 hospital market basket weights	FY 1992-based hospital market basket weights
1. Compensation	61.656	61.390
A. Wages and Salaries*	50.686	50.244
B. Employee Benefits*	10.970	11.146
2. Professional Fees*	5.401	2.127
3. Utilities	1.353	1.542
A. Fuel, Oil, and Gasoline	0.284	0.369
B. Electricity	0.833	0.927
C. Water and Sewerage	0.236	0.246
4. Professional Liability Insurance	0.840	1.189
5. All Other	30.749	33.752
A. All Other Products	19.537	24.825
(1.) Pharmaceuticals	5.416	4.162
(2.) Direct Purchase Food	1.370	2.314
(3.) Contract Service Food	1.274	1.072
(4.) Chemicals	2.604	3.666
(5.) Blood and Blood Products	0.875	.....
(6.) Medical Instruments	2.192	3.080
(7.) Photographic Supplies	0.204	0.391
(8.) Rubber and Plastics	1.668	4.750
(9.) Paper Products	1.355	2.078
(10.) Apparel	0.583	0.869
(11.) Machinery and Equipment	1.040	0.207
(12.) Miscellaneous Products	0.956	2.236
B. All Other Services	11.212	8.927
(1.) Telephone Services	0.398	0.581
(2.) Postage	0.857	0.272
(3.) All Other: Labor Intensive*	5.438	7.277
(4.) All Other: Non-Labor Intensive	4.519	0.796
Total	100.000	100.000

*Labor-related.
Note: Due to rounding, weights may not sum to total.

3. Selection of Price Proxies

After computing the FY 1997 cost weights for the proposed rebased hospital market basket, it is necessary to select appropriate wage and price proxies to monitor the rate of change for each expenditure category. Most of the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because a PPI would better reflect the prices faced by hospitals. For example, we used the PPI for ethical (prescription) drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price change at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, the consumer price indexes were used only if an appropriate PPI was not available, or if the expenditure was more similar to that of retail consumers in general rather than a purchase at the wholesale level. For example, the CPI for food purchased away from home was

used as a proxy for contracted food services.

• Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are appropriately not affected by shifts in employment mix.

Table 3 sets forth the complete proposed hospital market basket including cost categories, weights, and price proxies. For comparison purposes, the respective FY 1992-based market basket price proxies are listed as well. A summary outlining the choice of the various proxies follows the table.

TABLE 3.—PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, AND WEIGHTS, AND FY 1992-BASED AND PROPOSED FY 1997-BASED PRICE PROXIES

Expense categories	Proposed rebased FY 1997 hospital market basket weights	Proposed rebased FY 1997 hospital market basket price proxy	FY 1992 hospital market basket price proxy
1. Compensation	61.656		
A. Wages and salaries*	50.686	ECI-wages and salaries, civilian hospital workers.	CMS occupational wage proxy.
B. Employee benefits*	10.970	ECI—benefits, civilian hospital workers	CMS occupational benefit proxy.
2. Professional fees*	5.401	ECI—compensation for professional specialty & technical.	ECI—compensation for professional, specialty & technical.
3. Utilities	1.353		
A. Fuel, oil, and gasoline	0.284	PPI refined petroleum products	PPI refined petroleum products.
B. Electricity	0.833	PPI commercial electric power	PPI commercial electric power.
C. Water and sewerage	0.236	CPI–U water & sewerage maintenance	CPI–U water & sewerage maintenance.
4. Professional liability insurance	0.840	CMS professional liability insurance premium index.	CMS professional liability insurance premium index.
5. All other products	30.749		
A. All other products	19.537		
(1.) Pharmaceuticals	5.416	PPI ethical (prescription) drugs	PPI ethical (prescription) drugs.
(2.) Direct purchase food	1.370	PPI processed foods and feeds	PPI processed foods and feeds.
(3.) Contract service food	1.274	CPI–U food away from home	CPI–U food away from home.
(4.) Chemicals	2.604	PPI industrial chemicals	PPI industrial chemicals.
(5.) Blood and blood products	0.875	PPI blood and blood derivatives, human use.	N/A.
(6.) Medical instruments	2.192	PPI medical instruments & equipment	PPI medical instruments and equipment.
(7.) Photographic supplies	0.204	PPI photographic supplies	PPI photographic supplies.
(8.) Rubber and plastics	1.668	PPI rubber & plastic products	PPI rubber and plastic products.
(9.) Paper products	1.355	PPI converted paper and paperboard products.	PPI converted paper and paperboard products.
(10.) Apparel	0.583	PPI apparel	PPI apparel.
(11.) Machinery and equipment	1.040	PPI machinery and equipment	PPI machinery and equipment.
(12.) Miscellaneous products	0.956	PPI finished goods less food and energy	PPI finished goods.
B. All other services	11.212		
(1.) Telephone services	0.398	CPI–U telephone services	CPI–U telephone services.
(2.) Postage	0.857	CPI–U postage	CPI–U postage.
(3.) All other: labor intensive*	5.438	ECI—Compensation for private service occupations.	ECI—compensation for private service occupations.
(4.) All other: non-labor intensive	4.519	CPI–U all items	CPI–U all items.
Total	100.000		

*Labor related.

a. Wages and Salaries

For measuring the price growth of wages in the FY 1997-based market basket, we are proposing to use the ECI for civilian hospitals. This differs from the proxy used in the FY 1992-based index in which a blended occupational wage index was used. The blended occupational wage proxy used in the FY 1992-based index and the ECI for wages and salaries for hospitals both reflect a fixed distribution of occupations within the hospital. The major difference between the two proxies is in the treatment of professional and technical wages. In the blended occupational wage proxy, the professional and technical category is blended evenly between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy, instead of hospital-specific occupations as reflected in the ECI for hospitals. This blend was done to create a normative price index that did not reflect the market imperfections in the hospital labor markets that existed for much of the 1980s and early 1990s.

Between 1987 (the first year the ECI for hospitals was available, although the pattern existed before then using other measures of hospital wages) and 1994, the ECI for wages and salaries for hospital workers grew faster than the blended occupational wage proxy. This trend then reversed for the 1995 through 2000 period when the ECI grew slower than the blended occupational wage proxy each year. This is the apparent result of the shift of private insurance enrollees from fee-for-service plans to managed care plans and the tighter controls these plans exhibited over hospital utilization and incentives to shift care out of the inpatient hospital setting. More recently, the ECI for wages

and salaries for hospital workers is again growing faster than the blended occupational wage proxy, raising the question of whether the relationship between hospital wages and the occupational wage blend from 1994 through 2000 was the signaling of a new era in the competitiveness of the hospital labor market, or simply the temporary reversal of the long-term pattern of labor market imperfections in hospitals.

In order to answer this question, we researched the historical determinants of this relationship and estimated what the future market conditions are likely to be. Our analysis indicated that the driving force behind the long-term differential between hospital wages and the blended occupational wage proxy was the increased demand for hospital services and the subsequent increase in hospital utilization, particularly in outpatient settings. However, during the 1994–2000 period, the major force behind the reversal of the differential was the shift of enrollees to managed care plans that had tighter restrictions on hospital utilization and encouraged the shift of care out of the hospital setting. To a lesser extent, the robust economic growth and tight economy-wide labor markets that accompanied this period helped to reverse the differential as well. Over the last year or two, there has been a move back towards less restrictive plans, and a subsequent increase in the utilization of medical services. This recent surge appears to reflect the true underlying fundamentals of health care demand. This concept is reinforced by the similar patterns being observed for nursing homes and other health sectors as well. This is an important development, specifically when compared to the ECI for wages and salaries for nursing homes, which reflect less skilled occupations, yet still experienced a similar acceleration in wage growth. Thus, we would expect that this recent surge in hospital wages is reflective of competitive labor market conditions, and would likely persist only as long as the underlying demand for health care was accelerating.

While the shift to managed care plans had a noticeable one-time effect, we do feel that the hospital labor market is more competitive than prior to this period and that the expected shift towards more restrictive insurance plans over the coming decade will act to create a wage differential that reflects the underlying increases in demand for hospital services. As shown in Table 5, using the ECI has only a minor overall impact (0.1 percentage point per year) from FY 1995 through FY 2001 on the hospital market basket. For FY 2003, the proposed hospital market basket is forecast to increase 0.2 percentage points faster (3.3 vs. 3.1) than it would have if the occupational blend had been used. Based on this, we are proposing to use the ECI for wages and salaries for hospitals and the ECI for benefits for hospitals as the proxies in the hospital market basket for wages and benefits, respectively. The ECI met our criteria of relevance, reliability, availability, and timeliness. Relevance means that the proxy is applicable and representative of the cost category that it proxies. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Availability means that the proxy is publicly available. Timeliness implies that the proxy is published regularly, at least once a quarter.

b. Employee Benefits

The proposed FY 1997-based hospital market basket uses the ECI for employee benefits for civilian hospitals. This differs from the FY 1992-based index in which a blended occupational index was used. Our conclusions were based on a similar analysis that was done for the wages and salaries proxy described above.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category since it includes occupations such as management and consulting, legal, accounting and engineering services. The same price measure was used in the FY 1992-based market basket.

d. Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) was applied to this component. The same price measure was used in the FY 1992-based market basket.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) was applied to this component. The same price measure was used in the FY 1992-based market basket.

f. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers (CPI Code # CUUR0000SEHG01) was applied to this component. The same price measure was used in the FY 1992-based market basket.

g. Professional Liability Insurance

The percentage change in the hospital professional liability insurance price as estimated by the CMS Hospital Malpractice Index was applied. In the FY 1992-based market basket, the same proxy was used.

We are currently conducting research into improving our proxy for professional liability insurance. This research includes subcontracting with ANASYS through a contract with DRI-WEFA to extend the results of its NHMIS survey to set up a sample of hospitals from which malpractice insurance premium data will be directly collected. This new information, which would include liability estimates for hospitals that self-insure, would be combined with our current proxy data to obtain a more accurate price measure. Depending on the timing of this new information, the proxy for professional liability insurance in the market basket may be modified for the final rule. In addition, we are researching a BLS PPI for malpractice premiums that may be a more appropriate proxy for this cost category.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (Commodity Code # PPI283D#RX) was applied to this variable. This is a special index produced by BLS. The previous price proxy used in the FY 1992-based index (Commodity Code #0635) was discontinued after BLS revised its indexes.

i. Food, Direct Purchases

The percentage change in the price of processed foods and foods as measured by the PPI (Commodity Code #02) was applied to this component. The same price measure was used in the FY 1992-based market basket.

j. Food, Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEFV) was applied to this component. The same price measure was used in the FY 1992-based market basket.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) was applied to this component. While the chemicals in this category include industrial as well as other types

of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, Commodity Code #061 is the appropriate proxy. The same price measure was used in the FY 1992-based market basket.

l. Blood and Blood Products

The percentage change in the price of blood and derivatives for human use as measured by the PPI (Commodity Code #063711) was applied to this component. As discussed earlier in this preamble, a comparable cost category was not available in the FY 1992-based market basket.

We are proposing that the blood and blood products cost category use the PPI for blood and blood derivatives as its price proxy. This proxy is relevant, reliable, available, and timely. We considered placing the blood weight in the Chemicals or Pharmaceuticals cost category, but found this made only minor changes to the total index. We also considered constructing an index based on blood cost data received from the American Red Cross, America's Blood Centers, and Zeman and Company. However, these data are collected annually and not widely available. The PPI for blood and blood derivatives was the only index we found that met all of our criteria.

m. Surgical and Medical Equipment

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) was applied to this component. The same price measure was used in the FY 1992-based market basket.

n. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) was applied to this component. The same price measure was used in the FY 1992-based market basket.

o. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) was applied to this component. The same price measure was used in the FY 1992-based market basket.

p. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) was used. The same price measure was used in the FY 1992-based market basket.

q. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) was applied to this component. The same price measure was used in the FY 1992-based market basket.

r. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) was applied to this component. The same price measure was used in the FY 1992-based market basket.

s. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) was applied to this component. The percentage change in the price of all finished goods was used in the FY 1992-based market basket. This change was made to remove the effect of food and energy prices, which are already captured elsewhere in the market basket.

t. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEED) was applied to this component. The same price measure was used in the FY 1992-based market basket.

u. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEEC01) was applied to this component. The same price measure was used in the FY 1992-based market basket.

v. All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry was applied to this component. The same price measure was used in the FY 1992-based market basket.

w. All Other Services, Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code # CUUR0000SA0) was applied to this component. The same price measure was used in the FY 1992-based market basket.

For further discussion of the rationale for choosing many of the specific price proxies, we reference the August 30, 1996 final rule (61 FR 46326). Table 4 shows the historical and forecasted updates under both the proposed FY 1997-based and the FY 1992-based market baskets. For comparison purposes, the FY 1997-based index incorporating different wage and benefit proxies is included in Table 5.

TABLE 4.—FY 1992-BASED AND PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Prospective rebased 1997 hospital market basket	FY 1992-based market basket
Historical data:		
FY 1995	2.8	3.1
FY 1996	2.3	2.4
FY 1997	1.6	2.1
FY 1998	2.7	2.9
FY 1999	2.7	2.5
FY 2000	3.3	3.6
FY 2001	4.2	4.1
Average FYs 1995–2001	2.8	3.0
Forecast:		
FY 2002	3.7	2.8
FY 2003	3.3	3.0
FY 2004	2.9	3.2

TABLE 4.—FY 1992-BASED AND PROPOSED FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004—Continued

Fiscal year (FY)	Prospective rebased 1997 hospital market basket	FY 1992-based market basket
Average FYs 2002–2004	3.3	3.0

Source: Global Insights, Inc, DRI–WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

Table 5 indicates that switching the proxy for wages and benefits to the ECI for Civilian Hospitals has a minimal effect on the FY 2003 update and a minimal effect over time. However, we believe that it is a more appropriate measure of price change in hospital wages and benefit prices given the current labor market conditions facing hospitals.

TABLE 5.—PROPOSED 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Proposed rebased 1997 hospital market basket using ECIs for wages and benefits	Proposed rebased 1997 market basket using occupational wage and benefit proxies
Historical data:		
FY 1995	2.8	2.9
FY 1996	2.3	2.5
FY 1997	1.6	2.3
FY 1998	2.7	3.2
FY 1999	2.7	2.9
FY 2000	3.3	3.5
FY 2001	4.2	4.0
Average FYs 1995–2001	2.8	3.0
Forecast:		
FY 2002	3.7	3.0
FY 2003	3.3	3.1
FY 2004	2.9	3.1
Average FYs 2002–2004	3.3	3.

Source: Global Insights, Inc, DRI–WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

The reintroduction of a cost component for blood and blood products in the market basket also does not make a noticeable impact on the market basket. Table 6 shows the proposed FY 1997-based market basket percentage change with blood broken out separately compared to market baskets with blood included in either chemicals or drugs.

TABLE 6.—PROPOSED 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, USING COST CATEGORIES FOR BLOOD AND BLOOD PRODUCTS, 1995–2004

Fiscal year (FY)	Proposed FY 1997-based market basket		
	With blood as a separate category	With blood included in chemicals	With blood included in drugs
Historical data:			
FY 1995	2.8	2.9	2.8
FY 1996	2.3	2.3	2.4
FY 1997	1.6	1.6	1.6
FY 1998	2.7	2.7	2.8
FY 1999	2.7	2.5	2.7
FY 2000	3.3	3.4	3.3
FY 2001	4.2	4.2	4.2
Average FYs 1995–2001	2.8	2.8	2.8
Forecast:			
FY 2002	3.7	3.6	3.7
FY 2003	3.3	3.3	3.3
FY 2004	2.9	3.0	3.0
Average FYs 2002–2004	3.3	3.3	3.3

Source: Global Insights, Inc, DRI-WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

4. Labor-Related Share

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act direct the Secretary to estimate from time to time the proportion of payments that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *''.

In its June 2001 Report to Congress, MedPAC recommended that ''To ensure accurate input-price adjustments in Medicare's prospective payment systems, the Secretary should reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets.'' (Report to the Congress: Medicare in Rural America, p. 80, Recommendation 4D.) MedPAC believes that the labor-related share is an estimate of the national average proportion of providers' costs associated with inputs that are *only* affected by local market wage levels. MedPAC recommended the labor-related share include the weights for wages and salaries, fringe benefits, contract labor, and other labor-related costs for locally purchased inputs only. By changing the definition, and thereby lowering the labor-related share, funds would be transferred from urban to rural hospitals, which generally have wage index values less than 1.0.

Given the recommendation by MedPAC and our proposal to rebase and revise the hospital market basket, we have reviewed the definition and methodology of the labor-related share. In addition, we reviewed the differences between urban and rural hospitals, updated regression results, and began reviewing possible alternative methodologies for calculating the labor-related share.

The labor-related share is used to determine the proportion of the national prospective payment system base payment rate to which the area wage index is applied. In the past we have defined the labor-related share for prospective payment system acute care hospitals as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. The labor-related share for the acute care hospital inpatient prospective payment system market basket has been the sum of the weights for wages and salaries, fringe benefits, professional fees, contract labor, postage, business services, and labor-intensive services.

The difference between the CMS definition of the labor-related share and MedPAC's recommendation is that MedPAC includes inputs that can only be purchased in the local labor market, while CMS' includes inputs that are related to, influenced by, or vary with the local labor market, even if those services may be purchased at the national level. We believe our measure of the labor-related share reflects the cost of those inputs that are likely purchased in the local market, and is consistent with the requirements under sections 1886(d)(2)(H) and (d)(3)(E) of the Act described at the beginning of section IV.A.4. of this proposed rule.

In connection with the rebasing and revising of the prospective payment system hospital market basket to 1997 data, we are proposing to recalculate the labor-related share of the standardized amounts. Our methodology is consistent with that used in the past to determine the labor-related share, which is the summation of the cost categories from the market basket deemed to vary with the local labor market. Based on the relative weights listed in Table 7, the proposed labor-related portion (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) of the prospective payment system hospital market basket is 72.5 percent, and the nonlabor-related portion is 27.5 percent. By capturing more than just the direct labor costs that are available from the Medicare cost reports, our definition captures the ''buy-versus-hire'' decisions hospitals make in the purchase of their inputs. Accordingly, effective with discharges occurring on or after October 1, 2002, we are proposing to use these revised labor-related and nonlabor-related shares of the large urban and other areas' standardized amounts used to establish the prospective payment rates. Table 7 compares the FY 1992-based labor-related share with the proposed FY 1997-based labor-related share. As shown in Table 7, we have removed postage costs from the proposed FY 1997-based labor-related share because we do not believe these costs are likely to vary with the local labor market. Also, by changing the data source used to determine professional fees, the weight for that category has increased significantly.

TABLE 7.—LABOR-RELATED SHARE

Cost category	FY 1992-based weight	Proposed 1997-based weight	Difference
Wages and salaries	50.244	50.686	0.442
Fringe benefits	11.146	10.970	−0.176
Nonmedical professional fees	2.127	5.401	3.274
Postal services*	0.272	.....	−0.272
Other labor-intensive services**	7.277	5.438	−1.839
Total labor-related	71.066	72.495	1.429
Total nonlabor-related	28.934	27.505	−1.429

* No longer considered to be labor-related.

** Other labor-intensive services includes landscaping services, services to buildings, detective and protective services, repair services, insurance services, laundry services, auto parking and repairs, physical fitness facilities, other medical services, colleges and professional schools, and other government enterprises.

We are concerned that the result of this methodology could have negative impacts that would fall predominantly on rural hospitals and are interested in public comments on alternative methodologies. While we are not proposing to change the methodology for calculating the labor-related share in this proposed rule, we have begun the research necessary to reevaluate the current assumptions used in determining this share. This reevaluation is consistent with the MedPAC recommendation in MedPAC's June 2001 report. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine

the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or just a portion of professional fees and nonlabor intensive services should be considered labor-related. Although we have not completed our research into this issue, we are summarizing some of our preliminary findings below. We encourage comments on this research and any information that is available to help determine the most appropriate measure.

The compensation share of costs for hospitals in rural areas was higher on average than the compensation share for hospitals in urban areas. Using FY 1997 Medicare cost report data, rural areas had an average compensation share of 62.7 percent, while urban areas had a share of 61.5 percent. This compares to a share of 61.7 percent for all hospitals. These findings were validated consistently through our regression analysis, described in more detail below, as the coefficient on the wage index was higher when the regressions were run only for rural hospitals compared to when the regressions were run only for urban hospitals. Based on these findings, it does not appear that using a national average labor share for all hospitals to adjust the national payment rate by the area wage index disadvantages rural hospitals that tend to have a wage index value below 1.0.

Our research attempted to validate our national average labor share by conducting regression analysis to determine the proportion of hospital's costs that varied with the area wage index. We have conducted this type of regression analysis before in helping to determine the labor-related share, most recently for the SNF prospective payment system (66 FR 39585). Our first step was to edit the data, which had significant outliers in some of the variables we used in the regressions. We originally began with an edit that excluded the top and bottom 5 percent of reports based on average Medicare cost per discharge and number of discharges. We also used edits to exclude reports that did not meet basic criteria for use, such as having costs greater than 0 for total, operating, and capital for the overall facility and for only the Medicare proportion. We also required that the hospital occupancy rate, length of stay, number of beds, full-time equivalents (FTEs), and overall and Medicare discharges be greater than 0. Finally, we excluded reports with occupancy rates greater than 1.

Our initial regression specification (in log form) was the Medicare operating cost per Medicare discharge as the dependent variable and the independent variables being the area wage index, the case mix index, the ratio of interns and residents per bed (as proxy for IME status), and a dummy for large urban hospitals. This regression produced a coefficient for all hospitals for the area wage index of 0.638 (which is equivalent to the labor share and can be interpreted as an elasticity because of the log specification) with an adjusted R-squared of 64.3. While on the surface this would appear to be a reasonable result, this same specification for urban hospitals had a coefficient of 0.532 (adjusted R-squared = 53.2) and a coefficient of 0.709 (adjusted R-squared = 36.4) for rural hospitals. This highlighted some apparent problems with the specification because the overall regression results appear to be masking underlying problems. It would not seem reasonable that urban hospitals would have a labor share below their actual compensation share or that the discrepancy between urban and rural hospitals would be this large. The other major problem with the regression was that the coefficient on the case-mix index was significantly below 1.0 for each specification. When we standardized the Medicare operating cost per Medicare discharge for case mix, the fit fell dramatically and the urban/rural discrepancy became even larger.

Based on this initial result, we tried two modifications to the regressions to correct for the underlying problems. First, we edited the data differently to determine if a few reports were causing the inconsistent results. We found that when we tightened the edits, the wage index coefficient was lower and the fit was worse. When we loosened the edits, we found higher wage index coefficients and still a worse fit. Second, we added variables to the regression equation to attempt to explain some of the variation that was not being captured. We found the best fit occurred when the following variables were added: the occupancy rate, the number of hospital beds, a dummy for control status, the Medicare length of stay, the number of FTEs per bed, and the age of fixed assets. The result of this specification was a wage index coefficient of 0.620 (adjusted R-squared = 68.7), with the regression on rural hospitals having a coefficient of 0.772 (adjusted R-squared = 45.0) and the regression on urban hospitals having a coefficient of 0.474 (adjusted R-squared = 60.9). Neither of these alternatives seemed to help the underlying difficulties with the regression analysis.

Because the market basket method determines the proportion of labor-related costs for the entire hospital, not just Medicare costs (due to the unavailability of Medicare specific data for such detailed cost categories) we also ran the regressions on overall hospital operating cost per discharge. The initial specification (only 4 independent variables) produced similar results to those discussed above, that is, what appeared to be a reasonable overall share but with major problems underlying the data. The more detailed specification also did not improve the results over the previous runs.

Because of these problems, we did not believe the regression analysis was producing enough sound evidence at this point for us to make the decision to change from the current method for calculating the labor-related share using market basket categories. We plan to continue to analyze these data and work on alternative specifications, including working with MedPAC, which has done a similar analysis in its studies of payment adequacy in the past. We welcome comments on this approach, given the difficulties we have encountered.

We also have been examining ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market. Specifically, we have been looking at the professional fees and labor intensive cost categories to determine if only a proportion of the costs in these categories should be considered labor-related, not the entire cost category. Professional fees include management and consulting fees, legal services, accounting services, and engineering services. Labor-intensive services are mostly building services, but also include other maintenance and repair and insurance services. While we have identified some possible approaches for accomplishing this, we do not believe at this point that we have completely validated them and thus are not proposing to change from our current method. Below we briefly describe the possible approaches and some of the issues surrounding these approaches.

One possible option would be to only include in the labor-related share the compensation portion of the cost category for each industry included in professional fees and labor-intensive services. This could be done using data from the 1997 BES, which reports detailed cost categories by industry (SIC) code. For example, management and consulting fees (SIC 874) is one of the major pieces of professional fees. The BES indicates that compensation accounts for 59.2 percent of operating costs in management and consulting

fees. If we only considered for inclusion in the labor-related share the portion that is compensation, this would result in a lower labor share. However, at this point, there does not appear to be enough information available from the BES to do this for every industry code. It is also not clear that at least some proportion of noncompensation costs of these inputs for hospitals would not vary with the local labor market. We are still researching the appropriateness of this option and whether it could be used to assist in determining the labor-related share.

Another possible option would be to use data from the Bureau of the Census' 1992 Enterprise Statistics to attempt to determine the proportion of costs for professional fees and labor-intensive services associated with centrally located overhead. That is, could we identify the proportion of costs that are borne in a central location such that they would not be related to the local labor market? The Enterprise Statistics include payroll data for both auxiliary establishments of a multiestablishment company and the entire company. Since auxiliary establishments primarily manage, administer, service, and support the activities of other establishments of the company, we were considering using this information to estimate the proportion of professional fees and labor-intensive services associated with central locations instead of with the location of the hospital. The Enterprise Statistics data are available for specific enterprise industry codes (EIC) that could seemingly be matched to the industry codes from the I–O used to determine professional fees and labor-intensive services. The methodology would consist of determining the auxiliary establishments payroll share of the total establishment, and subtracting that portion from the compensation portion of expenses for each I–O industry code. The initial research into this method is pointing out some difficulties in matching industry and EIC codes since the Enterprise Statistics do not contain as much detail as the I–O. In addition, it is not clear yet that this method would remove the appropriate amount of central office labor costs. We will continue to research this option, but at this time we are not proposing to use it in the calculation of the labor-related share.

We plan to continue researching whether an alternative methodology for determining the labor-related share would be more appropriate than our current methodology, including working with MedPAC. We plan to complete this research prior to August 1 and would make the appropriate changes in the final rule if we found another methodology to be superior to our current methodology. At this time, we are proposing to continue to use our existing methodology in determining the labor-related share.

5. Separate Market Basket for Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

In its March 1, 1990 report, ProPAC recommended that we establish a separate market basket for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system. Effective with FY 1991, we adopted ProPAC's recommendation to implement separate market baskets. (See the September 4, 1990 final rule (55 FR 36049).) Prospective payment system hospitals and excluded hospitals and units tend to have different case mixes, practice patterns, and composition of inputs. The fact that excluded hospitals are not included under the acute care hospital inpatient prospective payment system in part reflects these differences. Studies completed by CMS, ProPAC, and the hospital industry have documented different weights for excluded hospitals and units and prospective payment system hospitals.

The excluded hospital market basket is a composite set of weights for Medicare-participating psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. We are proposing to use cost report data for excluded freestanding hospitals whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay for excluded hospitals, except psychiatric hospitals. A tighter measure of Medicare length of stay within 8 percent (that is, 8 percent higher or lower) of the total facility average length of stay is proposed for freestanding psychiatric hospitals. This was done because psychiatric hospitals have a relatively small proportion of costs from Medicare and a relatively small share of Medicare psychiatric cases. While the 15 percent length of stay edit was used for the FY 1992-based index, the tighter, 8 percent edit for psychiatric hospitals was not. We believe that limiting our sample to hospitals with a Medicare average length of stay within a comparable range to the total facility average length of stay provides a more accurate reflection of the structure of costs for treating Medicare patients.

Table 8 compares major weights in the proposed rebased FY 1997 market basket for excluded hospitals with weights in the proposed rebased FY 1997 market basket for acute care prospective payment system hospitals. Wages and salaries are 51.998 percent of total operating costs for excluded hospitals compared to 50.686 percent for acute care prospective payment hospitals. Employee benefits are 11.253 percent for excluded hospitals compared to 10.970 percent for acute care prospective payment hospitals. As a result, compensation costs (wages and salaries plus employee benefits) for excluded hospitals are 63.251 percent of costs compared to 61.656 percent for acute care prospective payment hospitals, reflecting the more labor-intensive services conducted in excluded hospitals.

A significant difference in the category weights also occurs in pharmaceuticals. Pharmaceuticals represent 5.416 percent of costs for acute care prospective payment hospitals and 6.940 percent for excluded hospitals. The weights for the excluded hospital market basket were derived using the same data sources and methods as for the acute care prospective payment market basket as outlined previously. Differences in weights between the proposed excluded hospital and acute care prospective payment hospital market baskets do not necessarily lead to significant differences in the rate of price growth for the two market baskets. If individual wages and prices move at approximately the same annual rate, both market baskets may have about the same overall price growth, even though the weights may differ substantially, because both market baskets use the same wage and price proxies. Also, offsetting price increases for various cost components can result in similar composite price growth in both market baskets.

TABLE 8.—PROPOSED FY 1997-BASED EXCLUDED HOSPITAL AND PROSPECTIVE PAYMENT HOSPITAL MARKET BASKETS, COMPARISON OF SIGNIFICANT WEIGHTS

Category	Proposed rebased 1997 excluded hospital market basket	Proposed rebased 1997 Prospective Payment System hospital market basket
Wages and salaries	51.998	50.686
Employee benefits	11.253	10.970
Professional fees	4.859	5.401
Pharmaceuticals	6.940	5.416
All other	24.950	25.527
Total	100.000	100.000

Table 9 lists the cost categories, weights, and proxies for the proposed FY 1997-based excluded hospital market basket. For comparison, the FY 1992-based cost category weights are included. The proxies are the same used in the proposed FY 1997-based acute care hospital inpatient prospective payment system market basket discussed above.

TABLE 9.—FY 1992-BASED AND PROPOSED FY 1997-BASED EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	Proposed rebased 1997 excluded hospital market basket weights	FY 1992-based excluded hospital market basket weights	FY 1997-based price proxy
1. Compensation	63.251	63.721	
A. Wages and salaries*	51.998	52.152	ECI-wages and salaries, civilian hospitals.
B. Employee benefits*	11.253	11.569	ECI-benefits, civilian hospitals.
2. Professional fees*	4.859	2.098	ECI-compensation for professional, specialty & technical.
3. Utilities	1.296	1.675	—
A. Fuel, oil, and gasoline	0.272	0.401	PPI commercial natural gas.
B. Electricity	0.798	1.007	PPI commercial electric power.
C. Water and sewerage	0.226	0.267	CPI–U water and sewerage maintenance.
4. Professional liability insurance	0.805	1.081	CMS professional liability insurance premiums index.
5. All other	29.790	31.425	—
A. All other products	19.680	24.227	—
(1) Pharmaceuticals	6.940	3.070	PPI ethical (prescription) drugs.
(2) Direct purchase food	1.233	2.370	PPI processed foods & feeds.
(3) Contract service food	1.146	1.098	CPI–U food away from home.
(4) Chemicals	2.343	3.754	PPI industrial chemicals.
(5) Blood and blood products	0.821	N/A	PPI blood and blood derivatives, human use.
(6) Medical instruments	1.972	3.154	PPI medical instruments & equipment.
(7) Photographic supplies	0.184	0.400	PPI photographic supplies.
(8) Rubber and plastics	1.501	4.865	PPI rubber & plastic products.
(9) Paper products	1.219	2.182	PPI converted paper & paperboard products.
(10) Apparel	0.525	0.890	PPI apparel.
(11) Machinery and equipment	0.936	0.212	PPI machinery & equipment.
(12) Miscellaneous products	0.860	2.232	PPI finished goods less food and energy.
B. All other services	10.110	7.198	—
(1) Telephone services	0.382	0.631	CPI–U telephone services.
(2) Postage	0.771	0.295	CPI–U postage.
(3) All other: labor intensive*	4.892	5.439	ECI-compensation for private service occupations.
(4) All other: Non-labor intensive	4.065	0.833	CPI–U all items.
Total	100.000	100.000	—

*Labor-related.
Note: Due to rounding, weights may not sum to total.

Table 10 shows the historical and forecasted updates under both the proposed FY 1997-based and the FY 1992-based excluded hospital market baskets.

TABLE 10.—FY 1992-BASED AND PROPOSED FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Proposed rebased 1997 excluded hospital market basket	FY 1992-based excluded hospital market basket
Historical data:		
FY 1995	2.7	3.2
FY 1996	2.4	2.5
FY 1997	1.7	2.0
FY 1998	3.0	2.7
FY 1999	2.9	2.4
FY 2000	3.3	3.6
FY 2001	4.3	4.1
Average FYs 1995–2001	2.9	2.9
Forecast:		
FY 2002	3.7	2.8
FY 2003	3.4	3.0
FY 2004	3.0	3.1
Average FYs 2002–2004	3.4	3.0

Source: Global Insights, Inc, DRI-WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

A comparison of the proposed FY 1997-based index incorporating the new wage and benefits proxies (ECIs) and updated occupational wage proxies is included in Table 11.

TABLE 11.—PROPOSED FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Proposed rebased 1997 excluded hospital market basket	
	Using ECIs for hospital wages and nenefits	Using occupational wage and benefit proxies
Historical data:		
FY 1995	2.7	2.9
FY 1996	2.4	2.5
FY 1997	1.7	2.3
FY 1998	3.0	3.4
FY 1999	2.9	3.1
FY 2000	3.3	3.5
FY 2001	4.3	4.0
Average FYs 1995–2001	2.9	3.1
Forecast:		
FY 2002	3.7	3.1
FY 2003	3.4	3.2
FY 2004	3.0	3.2
Average FYs 2002–2004	3.4	3.2

Source: Global Insights, Inc, DRI–WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

Like the proposed FY 1997-based prospective payment hospital index showed, there is little difference in the index over time when different compensation proxies are used. Table 12 shows the labor-related share for excluded hospitals.

TABLE 12.—LABOR-RELATED SHARE, EXCLUDED HOSPITALS

Cost category	FY 1992-based weight	Proposed FY 1997-based weight	Difference
Wages and salaries	52.152	51.998	−0.154
Fringe benefits	11.569	11.253	−0.316
Nonmedical professional fees	2.098	4.859	2.761
Postal services*	0.295	.....	−0.295
Other labor intensive services**	5.439	4.892	−0.547
Total labor-related	71.553	73.002	1.449

TABLE 12.—LABOR-RELATED SHARE, EXCLUDED HOSPITALS—Continued

Cost category	FY 1992-based weight	Proposed FY 1997-based weight	Difference
Total nonlabor-related	28.447	26.998	−1.449

*No longer considered to be labor-related.
**Other labor-intensive services includes landscaping services, services to buildings, detective and protective services, repair services, insurance services, laundry services, auto parking and repairs, physical fitness facilities, other medical services, colleges and professional schools, and other government enterprises.

B. Capital Input Price Index

The Capital Input Price Index (CIPI) was originally detailed in the September 1, 1992 **Federal Register** (57 FR 40016). There have been subsequent discussions of the CIPI presented in the May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), and August 30, 1996 (61 FR 46196) rules in the **Federal Register**. The August 30, 1996 rule discussed the most recent revision and rebasing of the CIPI to a FY 1992 base year, which reflects the capital cost structure facing hospitals in that year.

We are proposing to revise and rebase the CIPI to a FY 1997 base year to reflect the more recent structure of capital costs. To do this, we reviewed hospital expenditure data for the capital cost categories of depreciation, interest, and other capital expenses. As with the FY 1992-based index, we have developed two sets of proposed weights in order to calculate the proposed FY 1997-based CIPI. The first set of proposed weights identifies the proportion of hospital capital expenditures attributable to each capital expenditure category, while the second set of proposed weights is a set of relative vintage weights for depreciation and interest. The set of vintage weights is used to identify the proportion of capital expenditures within a cost category that is attributable to each year over the useful life of capital assets in that category. A more thorough discussion of vintage weights is provided later in this section.

Both sets of weights are developed using the best data sources available. In reviewing source data, we determined that the Medicare cost reports provided accurate data for all capital expenditure cost categories. We are proposing to use the FY 1997 Medicare cost reports for acute care prospective payment system hospitals, excluding expenses from hospital-based subproviders, to determine weights for all three cost categories: Depreciation, interest, and other capital expenses. We compared the weights determined from the Medicare cost reports to other data sources for 1997, specifically the Bureau of the Census' BES and the AHA Annual Survey, and found the weights to be consistent with those data sources.

Lease expenses are not a separate cost category in the CIPI, but are distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. We assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead, as was done in previous capital market baskets. The remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

Depreciation contains two subcategories: Building and fixed equipment and movable equipment. The split between building and fixed equipment and movable equipment was determined using the Medicare cost reports. This methodology was also used to compute the FY 1992-based index.

Table 13 presents a comparison of the proposed rebased FY 1997 capital cost weights and the FY 1992 capital cost weights.

TABLE 13.—COMPARISON OF FY 1992 AND PROPOSED REBASED FY 1997 COST CATEGORY WEIGHTS

Expense categories	FY 1992 weights	Proposed rebased FY 1997 weights	Price proxy
Total	1.0000	1.0000	
Total depreciation	0.6484	0.7135	
Building and fixed equipment depreciation	0.3009	0.3422	Boeckh Institutional Construction Index—vintage weighted (23 years).
Movable equipment depreciation	0.3475	0.3713	PPI for machinery and equipment—vintage weighted (11 years).
Total interest	0.3184	0.2346	
Government/nonprofit interest	0.2706	0.1994	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage weighted (23 years).
For-profit interest	0.0478	0.0352	Average yield on Moody's Aaa bonds—vintage weighted (23 years).
Other	0.0332	0.0519	CPI—Residential Rent.

Because capital is acquired and paid for over time, capital expenses in any given year are determined by past and present purchases of physical and financial capital. The vintage-weighted CIPI is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the purchase patterns of building and fixed equipment and movable

equipment over time. Because depreciation and interest expenses are determined by the amount of past and current capital purchases, we used the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the CIPI. Capital costs are inherently complicated and are determined by complex capital purchasing decisions over time, based on such factors as interest rates and debt financing. Capital is depreciated over time instead of being consumed in the same period it is purchased. The CIPI accurately reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital accumulation process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes. These unstable annual price changes do not reflect the actual annual price changes for Medicare capital-related costs. CMS's CIPI reflects the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we used a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. The AHA Panel Survey did provide time series of depreciation and interest expenses that could be used to infer capital purchases over time. Although the AHA Panel Survey was discontinued after September 1997, we were able to use all of the available historical data from this survey since our proposed base year is FY 1997.

In order to estimate capital purchases from AHA data on depreciation and interest expenses, the expected life for each cost category (building and fixed equipment, movable equipment, debt instruments) is needed. The expected life is used in the calculation of vintage weights. We used FY 1997 Medicare cost reports to determine the expected life of building and fixed equipment and movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the fixed asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 1997 cost reports, we determined the expected life of building and fixed equipment to be 23 years, and the expected life of movable equipment to be 11 years. By comparison, the FY 1992-based index showed that the expected life for building and fixed equipment was 22 years, while that for movable equipment was 10 years. Our analysis of data for FYs 1996, 1998, and 1999 indicates very little change in these measures over time.

We used the fixed and movable weights derived from the FY 1997 Medicare cost reports to separate the AHA Panel Survey depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. By multiplying the annual depreciation amounts by the expected life calculations from the FY 1997 Medicare cost reports, we determined year-end asset costs for building and fixed equipment and movable equipment. We subtracted the previous year asset costs from the current year asset costs and estimated annual purchases of building and fixed equipment and movable equipment back to 1963. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, we used the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh institutional construction index. Because building and fixed equipment has an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the 1997 average building and fixed equipment vintage weights.

For movable equipment vintage weights, we used the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the PPI for machinery and equipment. Because movable equipment has an expected life of 11 years, the vintage weights for movable equipment are deemed to represent the average purchase pattern of movable equipment over 11-year periods.

Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation is done for each year in the 11-year period, and for each of the twenty-four 11-year periods from 1963 to 1997. The average of the twenty-four 11-year periods is used to determine the FY 1997 average movable equipment vintage weights.

For interest vintage weights, we used the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel Survey. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the FY 1997 average interest vintage weights. The vintage weights for the FY 1992 CIPI and the proposed FY 1997 CIPI are presented in Table 14.

TABLE 14.—CURRENT AND PROPOSED VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year (from farthest to most recent)	Building and fixed equipment		Movable equipment		Interest	
	FY 1992 22 years	Proposed FY 1997 23 years	FY 1992 10 years	Proposed FY 1997 11 years	FY 1992 22 years	Proposed FY 1992 23 years
1	0.019	0.018	0.069	0.063	0.007	0.007
2	0.020	0.021	0.075	0.068	0.008	0.009
3	0.023	0.023	0.083	0.074	0.010	0.011
4	0.026	0.025	0.091	0.080	0.012	0.012
5	0.028	0.026	0.097	0.085	0.014	0.014
6	0.030	0.028	0.103	0.091	0.016	0.016
7	0.031	0.030	0.109	0.096	0.018	0.019
8	0.032	0.032	0.115	0.101	0.021	0.022
9	0.036	0.035	0.124	0.108	0.024	0.026
10	0.039	0.039	0.133	0.114	0.029	0.030
11	0.043	0.042	.....	0.119	0.035	0.035
12	0.047	0.044	.....	.....	0.041	0.039
13	0.050	0.047	.....	.....	0.047	0.045
14	0.052	0.049	.....	.....	0.052	0.049
15	0.055	0.051	.....	.....	0.059	0.053
16	0.059	0.053	.....	.....	0.067	0.059
17	0.062	0.057	.....	.....	0.074	0.065
18	0.065	0.060	.....	.....	0.081	0.072
19	0.067	0.062	.....	.....	0.088	0.077
20	0.069	0.063	.....	.....	0.093	0.081
21	0.072	0.065	.....	.....	0.099	0.085
22	0.073	0.064	.....	.....	0.103	0.087
23	.....	0.065	.....	.....	.....	0.090
Total	1.000	1.000	1.000	1.000	1.000	1.000

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate of increase for each expenditure category. Our proposed price proxies for the FY 1997-based CIPI are the same as those for the FY 1992-based CIPI. We still believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We ran the proposed FY 1997-based index using the Moody's Aaa bonds average yield and using the Moody's Baa bonds average yield as proxy for the for-profit interest cost category. There was no difference in the two sets of index percent changes either historically or forecasted. The rationale for selecting the price proxies is explained more fully in the August 30, 1996 final rule (61 FR 46196). The proposed proxies are presented in Table 13.

Global Insights, Inc., DRI–WEFA forecasts a 0.7 percent increase in the proposed rebased FY 1997 CIPI for FY 2003, as shown in Table 15.

TABLE 15.—FY 1992 AND PROPOSED FY 1997-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, 1995–2004

Federal fiscal year	CIPI, FY 1992-based	Proposed CIPI, FY 1997-based
1995	1.2	1.5
1996	1.0	1.3
1997	0.9	1.2
1998	0.7	0.9
1999	0.7	0.9
2000	0.9	1.1
2001	0.7	0.9
Average: FYs 1995–2001	0.9	1.1
Forecast:		
2002	0.6	0.8
2003	0.5	0.7
2004	0.6	0.7
Average: FYs 2002–2004	0.6	0.7

Source: Global Insights, Inc, DRI–WEFA, 1st Qtr. 2002; @USMACRO/MODTREND @CISSIM/TRENDLONG0202.

This 0.7 percent increase is the result of a 1.3 percent increase in projected vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.7 percent increase in other capital expense prices, partially offset by a 2.2 percent decrease in vintage-weighted interest rates in FY 2003, as indicated in Table 16.

TABLE 16.—CMS PROPOSED CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1985–2005

Fiscal year	Total	Total depreciation	Depreciation, building and fixed equipment	Depreciation, movable equipment	Interest	Other
Wgts FY 1997	1.000	0.7135	0.3422	0.3713	0.2346	0.0519
Vintage-Weighted Price Changes						
1995	1.5	2.7	4.0	1.6	−1.8	2.5
1996	1.3	2.5	3.8	1.4	−2.3	2.6
1997	1.2	2.3	3.6	1.2	−2.4	2.8
1998	0.9	2.1	3.3	0.9	−3.0	3.2
1999	0.9	1.9	3.2	0.7	−2.8	3.2
2000	1.1	1.7	3.1	0.4	−1.6	3.4
2001	0.9	1.5	2.9	0.1	−2.2	4.3
Forecast:						
2002	0.8	1.4	2.8	0.0	−2.2	4.0
2003	0.7	1.3	2.7	−0.1	−2.2	2.7
2004	0.7	1.3	2.5	−0.1	−2.1	2.8
2005	0.7	1.3	2.5	−0.1	−2.0	2.8

Rebasing the CIPI from FY 1992 to FY 1997 increased the percent change in the FY 2003 forecast by 0.2 percentage points, from 0.5 to 0.7 as shown in Table 15. The difference is caused mostly by changes in cost category weights, particularly the smaller weight for interest and larger weight for depreciation. Because the interest component has a negative price change associated with it for FY 2003, the smaller share it accounts for in the FY 1997-based index means it has less of an impact than in the FY 1992-based index. The changes in the expected life and vintage weights have only a minor impact on the overall percent change in the index.

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

A. Transfer Payment Policy

1. Expanding the Postacute Care Transfer Policy to Additional DRGs (§ 412.4)

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

Under section 1886(d)(5)(J) of the Act, which was added by section 4407 of Public Law 105–33, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary if the individuals are discharged to one of the following postacute care settings:

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

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

The Conference Agreement that accompanied Public Law 105–33 noted that ''(t)he Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a postacute care setting after a very short acute care hospital stay. The conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' (H.R. Report No. 105–217, 105th Cong., 1st Sess., 740 (1997).)

In the July 31, 1998 final rule (63 FR 40975), we implemented section 1886(d)(5)(J) of the Act, which directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs

to be subject to the special 10 DRG transfer rule:

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

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

The statute provides that, after FY 2000, the Secretary is authorized to expand this policy to additional DRGs. In July 1999, the previous Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, CMS did not propose any change to the postacute care settings or the 10 DRGs in FY 2001 or FY 2002.

Under contract with CMS (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the postacute care transfer provision. We included in the August 1, 2000 final rule (65 FR 47079) a summary of that analysis. Among other issues, the analysis sought to evaluate the reasonableness of expanding the transfer payment policy beyond the current 10 selected DRGs.

The analysis supported the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent choices based on the other criteria as well. Most have fairly high short-stay PAC rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

The HER report discussed the issues related to potentially expanding the postacute care transfer policy to all DRGs. In favor of this expansion, HER pointed to the following benefits:

- A simple, uniform, formula-driven policy;
- The same policy rationale exists for all DRGs;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive, short-stay, postacute care transfer policy for other DRGs.

The complete HER report may be obtained at: *http://www.cms.gov/medicare/ippsmain.htm.*

Consistent with HER's findings, we believe expanding the postacute care transfer policy to all DRGs may be the most equitable approach at this time, since a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, depending on the types of cases treated. We are considering implementing this expansion of the postacute transfer policy in the final rule. For example, a hospital specializing in some of the types of cases included in the current 10 DRG transfer policy would receive reduced payments for those cases transferred for postacute care after a brief acute inpatient stay, while a hospital specializing in cases not included in the current 10 DRGs may be just as aggressive in transferring its patients for postacute care, but it would receive full payment for those cases.

Another aspect of the issue is that some hospitals have fewer postacute care options available for their patients. In its June 2001 Report to Congress: Medicare in Rural America, MedPAC wrote: ''[a] shortage of ambulatory and post-acute care resources may prevent rural hospitals from discharging patients as early in the episode of care as urban hospitals would'' (page 68). MedPAC went on to note that the decline in length of stay for urban hospitals since 1989 was greater for urban hospitals than for rural hospitals (34 percent compared with 25 percent through 1999), presumably due to earlier discharges to postacute care settings. Although MedPAC contemplated returning money saved by expanding the policy to the base payment rate, thereby increasing payments for nontransfer cases, currently section 1886(d)(5)(I)(ii) of the Act provides that any expansion to the postacute transfer policy would not be budget neutral. (Budget neutrality refers to adjusting the base payment rates to ensure total aggregate payments are the same after implementing a policy change as they were prior to the change.) Nevertheless, over the long run, reducing the Medicare Trust Fund expenditures for patients who are transferred to a postacute care setting after a very short acute care hospital stay will improve the program's overall financial stability. Our analysis indicates that expanding the postacute care transfer policy to all DRGs would reduce program payments for these cases by approximately $1.9 billion for FY 2002.

If we were to expand the transfer policy to all DRGs, we would expand the list of those DRGs where a disproportionate share of the costs of the entire stay occurs early in the stay. We conducted analysis to identify those DRGs that would be eligible for the special transfer payment methodology specified in § 412.4(f)(2). As stated above, currently, three DRGs (DRGs 209, 210, and 211) are paid under a special transfer payment calculation whereby they receive 50 percent of the full DRG payment amount on the first day of the stay for cases transferred to a postacute care provider.

We identified cases that were transferred to home health care, SNFs, or long-term care, matching records by beneficiary identification numbers and discharge and admission dates. We standardized charges to account for differences in area wage levels, indirect medical education costs, and disproportionate share payments, and we reduced charges to costs using the available cost-to-charge ratios.

We then grouped the costs by DRG and length of stay. The average costs for transfer cases with a length of stay of 1 day were compared to the costs of transfer cases whose length of stay

approximated the geometric mean length of stay for that particular DRG. The average costs for the transfer cases with a length of stay of 1 day were also compared to costs for all cases with a length of stay approximating the geometric mean length of stay across the DRG. Based on this analysis, we identified the following DRGs that, if the postacute care transfer policy were to be expanded, would qualify for the special postacute care transfer payment policy of 50 percent of the full DRG payment for the first day of the stay:

- DRG 7 (Peripheral and Cranial Nerve and Other Nervous System Procedures with CC);
- DRG 159 (Hernia Procedures Except Inguinal and Femoral Age >17 with CC);
- DRG 218 (Lower Extremity and Humerus Procedure Except Hip, Foot, Femur Age >17 with CC);
- DRG 226 (Soft Tissue Procedures with CC);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC);
- DRG 306 (Prostatectomy with CC);
- DRG 308 (Minor Bladder Procedures with CC);
- DRG 315 (Other Kidney and Urinary Tract O.R. Procedures);
- DRG 493 (Laparoscopic Cholecystectomy without C.D.E. with CC); and
- DRG 497 (Spinal Fusion Except Cervical with CC).

This list contains DRGs not currently paid under the special formula (DRGs 209, 210, and 211 will continue to receive the special payment). All of the DRGs in the list meet the following criteria: The average costs of transfer cases on the first day equals the average costs of cases staying the geometric mean length of stay; the geometric mean length of stay is 4 days or greater; and there were at least 50 transfer cases occurring on the first day of the stay.

We also note that DRGs 263 and 264 (which are included in the current list of 10 DRGs subject to the postacute care transfer policy) would qualify for special payment, even though both DRGs have not previously received payment under the special payment provision. However, DRG 264 does qualify under the criteria described above for identifying cases for the potential expanded postacute care transfer policy. Because DRGs 263 and 264 are paired DRGs (that is, the only difference in the cases assigned to DRG 263 as opposed to DRG 264 is that the patient has a complicating or comorbid condition), we would include both DRGs under this expanded policy. If we were to include only DRG 264, there would be an incentive not to include a code identifying a complicating or comorbid condition, so that a transfer case would be assigned to DRG 264 instead of DRG 263 due to the higher per diem payment for DRG 264.

Rather than expand the postacute care transfer policy to all DRGs, another option that we are considering for the final rule is expanding the postacute care transfer policy only to additional DRGs that have high rates of transfers, similar to the initial implementation of only 10 DRGs. For example, an incremental expansion would be to add another 10 DRGs to the policy. Using the same criteria to identify DRGs with high postacute care transfer rates, we identified additional DRGs to include in the postacute care transfer policy. We note that three of the DRGs we identified are paired DRGs (that is, they contain a CC/no-CC split). For the same reason given above for treating paired DRGS consistently, we would include the pairs for the 10 DRGs identified. We estimate the impact of this approach would be to reduce payments to hospitals by approximately $916 million for FY 2002. Under this approach, discharges from the following 13 DRGs (in addition to the 10 DRGs already subject to the postacute care transfer policy) could be considered to be subject to an alternative postacute care transfer policy:

- DRG 12 (Degenerative Nervous System Disorders);
- DRG 79 (Respiratory Infections and Inflammations Age >17 with CC);
- DRG 80 (Respiratory Infections and Inflammations Age >17 without CC);
- DRG 107 (Coronary Bypass with Cardiac Catheterization);
- DRG 109 (Coronary Bypass with PTCA or Cardiac Catheterization);
- DRG 148 (Major Small and Large Bowel Procedures with CC);
- DRG 149 (Major Small and Large Bowel Procedures without CC);
- DRG 239 (Pathological Fractures and Musculoskeletal System and Connective Tissue Malignancy);
- DRG 243 (Medical Back Problems);
- DRG 320 (Kidney and Urinary Tract Diagnoses Age >17 with CC);
- DRG 321 (Kidney and Urinary Tract Diagnoses Age >17 without CC);
- DRG 415 (O.R. Procedure for Infections and Parasitic Diseases); and
- DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis).

Expanding the postacute care transfer policy in this limited manner, however, would retain many of the potential inequities of the current system. Although we are concerned about the potential for a large impact of implementing any expansion of the postacute care transfer payment policy, we believe that the current policy may create payment inequities across patients and across hospitals. By expanding the postacute transfer policy, we would expect to reduce or eliminate these possible inequities. Therefore, we are soliciting comments on the two options we have identified and discussed in this proposed rule. In the final rule, we could adopt one of the approaches discussed above, or some other approach based on comments received on this proposal for addressing this issue. If commenters submit comments on alternate approaches, we are asking them to also provide useful data relating to alternative DRGs to which the expansion should or should not apply and detailed supporting explanations.

If we adopt either of the proposals discussed above or a variation based on comments submitted, we would follow procedures similar to those that are currently followed for treating cases identified as transfers in the DRG recalibration process. That is, as described in the discussion of DRG recalibration in section II.C. of this proposed rule, additional transfer cases would be counted as a fraction of a case based on the ratio of a hospital's transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases.

2. Technical Correction

When we revised our regulations on payments for discharges and transfers under § 412.4 in the July 31, 1998 final rule (63 FR 41003), we inadvertently did not exclude discharges from one hospital area or unit to another inpatient area or unit of the hospital that is paid under the acute care hospital inpatient prospective payment system (§ 412.4(b)(2)) from the types of cases paid under the general rule for transfer cases. We are proposing to correct the regulation text to reflect our policy (as reflected in prior preamble language) that transfers from one area or unit within a hospital to another are not paid as transfers (except as described under the special 10 DRG rule at § 412.4(c)). We are proposing to correct this error by revising § 412.4(f)(1) to provide that only the circumstances described in paragraph (b)(1) and (c) of § 412.4 are paid as transfers under the general transfer rule. This proposed correction

would reflect the fact that transfers under § 412.4(b)(2) are to be paid as discharges and not transfers.

B. Sole Community Hospitals (SCHs) (§§ 412.77 and 412.92)

1. Phase-In of FY 1996 Hospital-Specific Rates

Under the acute care hospital inpatient prospective payment system, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in § 412.92.

To be classified as an SCH, a hospital either must have been designated as an SCH prior to the beginning of the hospital inpatient prospective payment system on October 1, 1983, or 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 between 25 and 35 miles from other like hospitals, and it—
  —Serves at least 75 percent of all inpatients, or at least 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 at least 75 percent of its area's inpatients except that some patients seek specialized care unavailable at the hospital.
- It is located between 15 and 35 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 to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge; or
- The updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113 added section 1886(b)(3)(I) to the Act, and section 213 of Public Law 106–554 made further amendments to that section of the Act extending to all SCHs the ability to rebase their hospital-specific rates using their FY 1996 operating costs, effective for cost reporting periods beginning on or after October 1, 2000. The provisions of section 1886(b)(3)(I) of the Act were addressed in the June 13, 2001 interim final rule with comment period (66 FR 32177) and were finalized in the August 1, 2001 final rule (66 FR 39872).

In the June 13, 2001 interim final rule, we correctly described the provisions of section 1886(b)(3)(I) of the Act, as amended, and their implementation. However, in the August 1, 2001 final rule, in summarizing the numerous legislative provisions that had affected payments to SCHs, we incorrectly described the application of the statutory provisions in the background section of the preamble on SCHs (66 FR 39872). (We wish to point out that the Addendum to the August 1, 2001 final rule accurately describes the calculation of the hospital-specific rate (66 FR 39944).) Specifically, the payment options that we described in the August 1, 2001 preamble language on SCHs were incorrect in that we did not include the Federal rate in the blends. Therefore, we are providing below a correct description of the provisions of section 1886(b)(3)(I) of the Act and clarifying their application in determining which of the payment options will yield the highest rate of payment for SCHs.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, the Federal rate is included in the blend, as set forth below:

- For discharges during FY 2001, 75 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates (identified in the statute as the subsection (d)(5)(D)(i) amount), plus 25 percent of the updated FY 1996 hospital-specific rate (identified in the statute as the ''rebased target amount'').
- For discharges during FY 2002, 50 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 50 percent of the updated FY 1996 hospital-specific rate.
- For discharges during FY 2003, 25 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 75 percent of the updated FY 1996 hospital-specific rate.
- For discharges during FY 2004 and subsequent fiscal years, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the disproportionate share hospital (DSH) adjustment, or the indirect medical education (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.

The regulation text of § 412.77 and § 412.92(d) that was revised to incorporate the provisions of section 1886(b)(3)(I) of the Act, as amended, and published in the June 13, 2001 interim final rule with comment period (66 FR 32192 through 32193) and finalized in the August 1, 2001 final rule (66 FR 39932), is accurate.

2. SCH Like Hospitals

Section 1886(d)(5)(D)(iii) of the Act provides that, to qualify as a SCH, a hospital must be not more than 35 road miles from another hospital. There are several other conditions under which a hospital may qualify as a SCH, including if it is the ''* * * sole source of inpatient hospital services reasonably available to individuals in a geographic area * * *'' because of factors such as the ''* * * absence of other like hospitals * * *'' We have defined a ''like hospital'' in regulations as a hospital furnishing short-term, acute

care (§ 412.92(c)(2)). Like hospitals refers to hospitals paid under the acute care hospital inpatient prospective payment system.

We have become aware that, in some cases, new specialty hospitals that offer a very limited range of services have opened within the service area of a SCH and may be threatening the special status of the SCH. For example, a hospital that offers only a select type of surgery on an inpatient basis would qualify under our existing rules as an SCH ''like hospital'' if it met the hospital conditions of participation and was otherwise eligible for payment under the acute care hospital inpatient prospective payment system. Under our existing regulations, a SCH could lose its special status due to the opening of such a specialty hospital, even though there is little, if any, overlap in the types of services offered by the SCH and the specialty hospital.

We believe that limiting eligibility for SCH status to hospitals without SCH like hospitals in their service area is a way to identify those hospitals that truly are the sole source of short-term acute-care inpatient services in the community. A limited-service, specialty hospital, by definition, would not offer an alternate source of care in the community for most inpatient services and therefore, we believe, should not be considered a ''like'' hospital with the effect of negating SCH status of a hospital that is the sole source of short-term acute care inpatient services in the community. Therefore, we are proposing to amend the definition of SCH like hospitals under § 412.92(c)(2), effective with cost reporting periods beginning on or after October 1, 2002, to exclude any hospital that provides no more than a very small percent of the services furnished by the limited-service facility that overlap with the services provided by the SCH. We believe the percentage of overlapping services should be sufficiently small so that we can ensure that only hospitals that truly are the sole source of short-term acute-care in their community qualify for SCH status. Therefore, we are proposing that this percentage be set at 3 percent. However, we are soliciting public comments on alternate appropriate levels of service overlap, as well as on the overall proposed change to the definition of like hospitals.

C. Outlier Payments: Technical Change (§ 412.80)

Sections 1886(d)(5)(A) and (d)(5)(K) of the Act provide for payments, in addition to the basic prospective payments, for ''outlier'' cases; that is, cases involving extraordinarily high costs. Cases qualify for outlier payments by demonstrating costs that exceed a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME (§ 412.105) and DSH (§ 412.106) payments for the case and, for discharges on or after October 1, 2001, additional payments for new technologies or services.

Implementing regulations for outlier payments are located in subpart F of part 412. Paragraph (a) of § 412.80 specifies the basic rules for making the additional outlier payments, broken down into three applicable effective periods. We have become aware that in paragraph (a)(2), which relates to outlier payments for discharges occurring on or after October 1, 1997, and before October 1, 2001, we did not include language to specify that the additional costs of outlier cases must exceed the standard DRG payment and any additional payment the hospital would receive for IME and for DSH, plus a fixed loss dollar threshold. Therefore, we are proposing to make a technical change by revising § 412.80(a)(2), applicable for discharges occurring during the period between October 1, 1997 and October 1, 2001, to include the appropriate language regarding additional payments for IME and payments for DSH. (We note that when we amended § 412.80 to incorporate the provisions on the additional payments for new technology under paragraph (a)(3) (66 FR 46924, September 7, 2001), effective October 1, 2001, we did include this language.)

D. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the 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 continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 1886(d)(8)(E) of the Act, as amended, 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. 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, a primary 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).

Although hospitals that are reclassified as rural under section 1886(d)(8)(E) of the Act are not permitted to reclassify through the MGCRB, effective 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. These hospitals may then take advantage of the waiver from the proximity requirements for reclassification.

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—

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

hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value includes all urban hospitals nationwide, and the proposed regional values are 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). These values are based on discharges occurring during FY 2001 (October 1, 2000 through September 30, 2001) and include bills posted to CMS's records through December 2001.

We are proposing 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, 2002, must have a case-mix index value for FY 2001 that is at least—

- 1.3229; 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 median case-mix index values by region are set forth in the following table:

Region	Case-Mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2089
2. Middle Atlantic (PA, NJ, NY)	1.2235
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.2985
4. East North Central (IL, IN, MI, OH, WI)	1.2377
5. East South Central (AL, KY, MS, TN)	1.2459
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1616
7. West South Central (AR, LA, OK, TX)	1.2641
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3255
9. Pacific (AK, CA, HI, OR, WA)	1.2779

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2001 MedPAR file, which will contain data from additional bills received through March 31, 2002.

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

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2001 (that is, October 1, 2000 through September 30, 2001). That is the latest year for which we have complete discharge data available.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have as the number of discharges for its cost reporting period that began during FY 2001 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, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,905
2. Middle Atlantic (PA, NJ, NY)	8,648
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	8,914
4. East North Central (IL, IN, MI, OH, WI)	8,040
5. East South Central (AL, KY, MS, TN)	6,748
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,696
7. West South Central (AR, LA, OK, TX)	6,220
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,167
9. Pacific (AK, CA, HI, OR, WA)	7,053

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals. These numbers will be revised in the final rule based on the latest FY 2001 cost report data.

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, 2002, must have at least 3,000 discharges for its cost reporting period that began during FY 2001.

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

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment for a Medicare discharge to reflect the higher indirect operating costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the IME adjustment factor. 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 1886(d)(5)(B)(ii)(VII) of the Act provides that, for discharges occurring during FY 2003 and thereafter, the ''c'' variable, or formula multiplier, is 1.35. The formula multiplier of 1.35 represents a 5.5-percent increase in IME payment for every 10-percent increase in the resident-to-bed ratio.

2. Temporary Adjustments to the FTE Cap To Reflect Residents Affected by Residency Program Closure: Resident-to-Bed Ratio for Displaced Residents (§§ 412.105(a) and (f)(1)(ix))

In the August 1, 2001 hospital inpatient prospective payment system final rule (66 FR 39899), we expanded the policy at existing § 413.86(g)(8) (proposed to be redesignated as § 413.86(g)(9) in this proposed rule), which allows a temporary adjustment to a hospital's FTE cap when a hospital trains additional residents because of another hospital's closure, to also allow a temporary adjustment when a hospital trains residents displaced by the closure of another hospital's residency program (but the hospital itself remains open). We revised regulations at existing § 413.86(g)(8) to state 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. We defined ''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. The methodology for adjusting the caps for the ''receiving'' hospital and the ''hospital that closed its program'' as they apply to the IME adjustment and direct GME payments is set forth in the regulations at existing §§ 412.105(f)(1)(ix) and 413.86(g)(8)(iii), respectively.

In the August 1, 2001 rule, we noted a commenter who requested that CMS further revise the regulations to grant temporary relief to hospitals in calculating the IME adjustment with regard to application of the resident-to-bed ratio cap (66 FR 39900). The commenter believed that while the cap on the number of residents has been temporarily adjusted, if the receiving hospital is not allowed to also adjust its resident-to-bed ratio in the prior year, the lower resident-to-bed ratio from the prior year would act to reduce the IME payments to the receiving hospital. The commenter suggested that, similar to the exception for residents in hospitals that begin new programs under § 412.105(a)(1), an adjustment should be made to the prior year's FTE residents equal to the increase in the current year's FTEs that is attributable to the transferred residents. In response to the commenter, we stated that we had decided not to allow the exclusion of these displaced residents in applying the resident-to-bed ratio cap. We explained that, while we believed that the receiving hospital may be held to a lower cap in the first year of training the displaced residents, the receiving hospital would benefit from the higher cap in the subsequent years as the displaced residents complete their training and leave that hospital. However, we indicated that we would consider suggestions for possible future changes to this policy.

We have revisited this policy and now realize that our rationale for not allowing the adjustment for displaced residents to the resident-to-bed ratio cap may have been faulty. We initially believed that, in the year following the last year in which displaced residents trained at the receiving hospital, the receiving hospital would benefit from the higher resident-to-bed ratio cap. However, we have determined that, while it is correct that the hospital will have a higher resident-to-bed ratio cap because of the higher number of displaced residents in the prior year, the receiving hospital's FTE count decreases as the displaced residents finish their training. Therefore, the receiving hospital would not need a higher resident-to-bed ratio cap to accommodate the remaining FTEs. Consequently, the higher resident-to-bed ratio cap in fact would not benefit the receiving hospital. Thus, we are now proposing to allow the exclusion of residents displaced by either the closure of another hospital's program or another hospital's closure in applying the resident-to-bed ratio cap. Specifically, assuming a hospital is eligible to receive a temporary adjustment to its FTE cap as described in existing § 413.86(g)(8), we are proposing that, solely for purposes of applying the resident-to-bed ratio cap in the *first* year in which the receiving hospital is training the displaced residents, the receiving hospital may adjust the numerator of the prior year's resident-to-bed ratio by the number of FTE residents that has caused the receiving hospital to exceed its FTE cap. (We note that this adjustment to the resident-to-bed ratio cap does not apply to changes in bed size). In the years subsequent to the first year in which the receiving hospital takes in the displaced residents, we believe an adjustment to the numerator of the prior year's resident-to-bed ratio is unnecessary because the receiving hospital's actual FTE count in those years would either stay the same or, as the displaced residents complete their training or leave that hospital, decrease each year. If all other variables remain constant, an increase in the current year's resident-to-bed ratio will establish a higher cap for the following year. In the second and subsequent years of training the displaced residents, the receiving hospital's resident-to-bed ratio for the current year would not be higher than the prior year's ratio and thus would not be limited by the resident-to-bed ratio cap.

In the cost reporting period following the departure of the last displaced residents, when the temporary FTE cap adjustment is no longer applicable, we are proposing that, solely for purposes of applying the resident-to-bed ratio cap, the resident-to-bed ratio be calculated *as if* the displaced residents had not trained at the receiving hospital in the prior year. In other words, in the year that the hospital is no longer training displaced residents, the attendant FTEs should be removed from the numerator of the resident-to-bed ratio from the prior year (that is, the resident-to-bed ratio cap). We believe that because we are proposing to allow the adjustment to the resident-to-bed ratio cap in the first year in which the receiving hospital trains displaced residents, it is equitable to remove those FTEs when calculating the resident-to-bed ratio cap after all the displaced

residents have completed their training at the receiving hospital.

The following is an example of how the receiving hospital's IME resident-to-bed ratio cap would be adjusted for displaced residents coming from either a closed hospital or a closed program:

Example: Hospital A has a family practice program with 3 residents. On June 30, 2002, Hospital A closes. Hospital B, which also has a family practice program, agrees to continue the training of Hospital A's residents beginning July 1, 2002. Its fiscal year end is June 30. As of July 1, 2002, the 3 residents displaced by the closure of Hospital A include 1 PGY1 resident, 1 PGY2 resident, and 1 PGY3 resident. In addition, Hospital B has 5 of its own residents, an IME FTE resident cap of 5, and 100 beds. Subject to the criteria under existing § 413.86(g)(8), Hospital B's FTE cap is temporarily increased to 8 FTEs. According to the proposed policy stated above, Hospital B's resident-to-bed ratio and resident-to-bed ratio cap would be determined as follows:

July 1, 2002 through June 30, 2003

• Resident-to-bed ratio: 5 FTEs + 3 displaced FTEs / 100 beds = .08 (line 3.18 of Worksheet E, Part A of the Medicare cost report, Form CMS 2552–96).

(Note: For purposes of applying the rolling average calculation at § 412.105(f)(1)(v) to this example, it is assumed that Hospital B had 5 FTE residents in both the prior and the penultimate cost reporting periods. Therefore, 5 FTEs are used in the numerator of the resident-to-bed ratio. Under § 412.105(f)(1)(v), displaced residents are added to the receiving hospital's rolling average FTE count in each year that the displaced residents are training at the receiving hospital.)

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2002) + *3 displaced FTEs (from fiscal year end June 30, 2003)* / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.08) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Therefore, Hospital B would use a resident-to-bed ratio of .08 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2003 through June 30, 2004

The PGY3 displaced resident has completed his or her family practice training on June 30, 2003 and has left Hospital B. Hospital B continues to train a displaced (now) PGY2 resident, and a displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 2 displaced FTEs / 100 beds = .07 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2003) + 3 displaced FTEs (from fiscal year end June 30, 2003) / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.07) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .07 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2004 through June 30, 2005

Another of the remaining displaced residents has completed his or her family practice training on June 30, 2004 and has left Hospital B. Hospital B continues to train one displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 1 displaced FTE / 100 beds = .06 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2004) + 2 displaced FTEs (from fiscal year end June 30, 2004) / 100 beds = .07 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.06) or the resident-to-bed ratio cap from the prior year (.07) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .06 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2005 through June 30, 2006

The last displaced resident has completed his or her family practice training on June 30, 2005 and has left Hospital B. Hospital B no longer trains any displaced residents, and, therefore, the last displaced resident is *removed* from the numerator of the resident-to-bed ratio cap.

• Resident-to-bed ratio: 5 FTEs + 0 displaced FTEs / 100 beds = .05

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2005) + *0 displaced FTEs (subtract 1 displaced FTE from FYE June 30, 2005)* / 100 beds = .05

• The lower of the resident-to-bed ratio from the current year (.05) or the resident-to-bed ratio cap from the prior year (.05) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .05.

We are proposing that this exception to the resident-to-bed ratio cap for residents coming from a closed hospital or a closed program would be effective for cost reporting periods beginning on or after October 1, 2002. We are proposing to revise § 412.105(a)(1) accordingly.

3. Counting Beds for the IME and DSH Adjustments (§ 412.105(b) and § 412.106(a)(l)(i))

As discussed under section V.E.2. of this proposed rule, the regulations for determining the number of beds to be used in calculating the resident-to-bed ratio for the IME adjustment are located at § 412.105(b). These regulations also are used to determine the number of beds for other purposes, including calculating the DSH adjustment at § 412.106(a)(l)(i). Section 412.105(b) specifies that the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. The number of available bed days does not include beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units.

Section 2405.3G of Part I of the Medicare Provider Reimbursement Manual (PRM) further defines ''available'' beds. Specifically, section 2405.3G states that an available bed is a bed that is permanently maintained and is available for use to lodge inpatients. However, there has been some uncertainty concerning the application of this definition of ''available.'' For example, a question arises as to whether beds in rooms or entire units that are unoccupied for extended periods of time should continue to be counted on the basis that, if there would ever be a need, they could be put into use.

Counting the number of beds in a hospital is intended to measure the size of a hospital's routine acute care inpatient operations. While hospitals necessarily maintain some excess capacity, we believe there is a point where excess capacity may distort the bed count. Therefore, we are proposing to revise our policy concerning the determination of a hospital's bed size to exclude beds that represent an excessive level of unused capacity. We believe this proposed refinement of our bed counting policy would better capture the size of a hospital's inpatient operations as described above.

We analyzed Medicare hospital data and found that, among hospitals that have between 100 and 130 beds, hospitals receiving DSH payments have lower occupancy rates than similar hospitals not receiving DSH payments. Because DSH payments are higher for urban hospitals with more than 100

beds, there may be an incentive for these hospitals to maintain excess capacity in order to qualify for those higher payments. Among 189 urban hospitals in this bed-size range that did not receive DSH payments during FY 1999, the average occupancy rate was 55 percent. However, among 294 urban hospitals in this bed-size range that did receive DSH payments during FY 1999, the average occupancy rate was 47 percent. Twenty-five percent of this group of hospitals (those receiving DSH payments) had occupancy rates below 35 percent. Among the hospitals not receiving DSH payments, 25 percent had occupancy rates below 43 percent. We believe this is indicative of a tendency among some small urban hospitals to maintain excess capacity in order to qualify for higher DSH payments. Therefore, we are proposing that if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital, would exclude beds that would result in an average annual occupancy rate below 35 percent (proposed § 412.105(b)(3)).

For example, if a hospital reports 105 beds for a cost reporting period, but has an average daily census of 26 patients for that same cost reporting period, its occupancy rate equals 24.8 percent (that is, 26/105). Because its occupancy rate is below the proposed minimum threshold of 35 percent, its maximum available bed count would be 74, which is the number of beds that would result in an occupancy rate of 35 percent, given an average daily census of 26 patients (that is, 26/.35).

We would otherwise continue to determine a hospital's bed size using existing regulations and program manual instructions, including the application of the available bed policy.

Following are the steps a hospital would undertake in determining its number of beds in a cost reporting period under our proposed policy:

Step 1: Determine the number of available beds using the existing regulations at § 412.105(b) and PRM instructions.

Step 2: Determine the average daily census by dividing the total number of inpatient acute care days in the hospital by the number of days in the cost reporting period.

Step 3: Divide the average daily census determined in step 2 by 35 percent.

Step 4: Use the *lower* of the number of beds as determined under step 1, or the result of step 3 for purposes of the IME and DSH calculations.

We believe that this proposed policy more accurately indicates the size of a hospital's operations. We are proposing to specify under proposed § 412.105(b)(3) that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent. We are proposing to make this proposed policy effective for discharges occurring on or after October 1, 2002.

F. Medicare-Dependent, Small Rural Hospitals: Ongoing Review of Eligibility Criteria (§ 412.108(b))

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 hospitals (MDHs). MDHs are eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system. Initially, in order to be classified as an MDH, a hospital must have met all of the following criteria:

- The hospital is located in a rural area (as defined in § 412.63(b);
- The hospital has 100 or fewer beds (as defined at § 412.105(b)) during the cost reporting period;
- The hospital is not classified as an SCH (as defined at § 412.92); and
- The hospital has no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during its cost reporting period beginning in FY 1987.

MDHs were eligible for a special payment adjustment under the acute care hospital inpatient 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 based on FY 1982 costs per discharge.
- The updated hospital-specific rate based on FY 1987 costs 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. The MDH provision expired effective with cost reporting periods beginning on or after October 1, 1994.

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 before October 1, 2006.

As specified in the June 13, 2001 interim final rule with comment period (66 FR 32172) and finalized in the August 1, 2001 final rule (66 FR 39883), section 212 of Public Law 106–554 provided that, effective with cost reporting periods beginning on or after April 1, 2001, a hospital has 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 (section 1886(d)(5)(G)(iv)(IV) of the Act). According to section 1886(d)(5)(G)(iv)(IV) of the Act, 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.

We would like to point out that cost reports undergo different levels of review. For example, some cost reports are settled with a desk review; others, through a full field audit. We believe the intention of the law is to provide hospitals the ability to qualify for MDH status based on their most recent settled cost reporting periods, each of which undergoes a level of audit in its settlement.

Hospitals that qualify under section 1886(d)(5)(G)(iv)(IV) of the Act are subject to the other provisions already in place for MDHs. That is, all MDHs are paid using the payment methodology as defined in § 412.108(c) and may be eligible for the volume decrease provision as defined in § 412.108(d).

Under existing classification procedures at § 412.108(b), a hospital must submit a written request to its fiscal intermediary to be considered for

MDH status based on at least two of its three most recently audited cost reporting periods for which the Secretary has a settled cost report (as specified in § 412.108(a)(1)(iii)(c)). The fiscal intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request and all of the required documentation. The intermediary's determination is subject to review under 42 CFR Part 405, Subpart R. MDH status is effective 30 days after the date of written notification of approval.

We are proposing to clarify and to codify in the regulations (proposed § 412.108(b)(4)) that an approved classification as an MDH remains in effect unless there is a change in the circumstances under which the classification was approved. That is, in order to maintain its eligibility for MDH status, a hospital must continue to be a small (100 or fewer beds), rural hospital, with no less than 60 percent Medicare inpatient days or discharges during either its cost reporting period beginning in FY 1987 or during at least two of its three most recently settled cost reporting periods.

We also are proposing to clarify and to codify in the regulations (proposed § 412.108(b)(5)) that the fiscal intermediary will evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status. This proposed clarification would include evaluating whether or not a hospital that qualified for MDH status under section 1886(d)(5)(G)(iv)(IV) of the Act continues to qualify for MDH status based on at least two of its three most recently settled cost reporting periods.

In addition, we are proposing, (proposed § 412.108(b)(6)) that if a hospital loses its MDH status, that change in status would become effective 30 days after the fiscal intermediary provides written notification to the hospital that it no longer meets the MDH criteria. If the hospital would like to be considered for MDH status after another cost reporting period has been audited and settled, we are proposing to require that the hospital must reapply by submitting a written request to its fiscal intermediary (proposed § 412.108(b)(7)). An MDH that continues to meet the criteria would not have to reapply.

G. Eligibility Criteria for Reasonable Cost Payments to Rural Hospitals for Nonphysician Anesthetists (§ 412.113(c))

Currently, a rural hospital can qualify and be paid on a reasonable cost basis for qualified nonphysician anesthetists (certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants) services for a calendar year beyond 1990 and subsequent years as long as it can establish before January 1 of that year that it did not provide more than 500 surgical procedures requiring anesthesia services, both inpatient and outpatient.

In the September 1, 1983 interim final rule with comment period that implemented the acute care hospital inpatient prospective payment system, we established the general policy to include, under that prospective payment system, inpatient hospital services furnished incident to a physician's service, with a time-limited exception for the inpatient hospital services of anesthetists (48 FR 39794). The purpose of this exception, which originally was for cost reporting periods beginning before October 1, 1986, was that the practice of physician-employer and anesthetist-employee was so widespread that we believed ''it would be disruptive of medical practice and adverse to the quality of patient care to require all such contracts to be renegotiated in the limited time available before the implementation of the prospective payment system.''

Section 2312 of Public Law 98–369 provided for reimbursement to hospitals on a reasonable cost basis as a pass-through for the costs that hospitals incur in connection with 27 the services of CRNAs. [3] Section 2312(c) provided that the amendment was effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

Section 9320 of Public Law 99–509 (which established a fee schedule for the services of nurse anesthetists) amended section 2312(c) of Public Law 98–369 by extending the pass-through provision for cost reporting periods beginning before January 1, 1989. Section 608 of Public Law 100–485 limited the pass-through provision effective during 1989, 1990, and 1991, to hospitals meeting the following criteria:

- As of January 1, 1988, the hospital employed or contracted with a certified nonphysician anesthetist;
- In 1987, the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 250 (or such higher number as the Secretary determines to be appropriate); and
- Each certified nonphysician anesthetist employed by, or under contract with, the hospital has agreed not to bill under Part B of Medicare for professional services furnished by the anesthetist at the hospital.

Subsequently, section 6132 of Public Law 101–239 amended section 608 of Public Law 100–458 by raising the established 250-procedure threshold to 500 procedures (effective for anesthesia services furnished on or after January 1, 1990), and extended the cost pass-through indefinitely. However, section 6132 of Public Law 101–239 left intact the requirement that the hospital must have not exceeded a maximum number of surgical procedures (effectively raised to 500), both inpatient and outpatient, requiring anesthesia services during 1987. Also, the statutory authority for the Secretary to adopt such other appropriate maximum threshold volume of procedures as determined appropriate was not affected by section 6132.

In light of the age of this provision, we undertook to reexamine the appropriateness of the current 500-procedure threshold. Nonphysician anesthetists who are not employed by or have a contractual relationship with a hospital paid under this provision may receive payments under a fee schedule. Payments under the fee schedule are generally somewhat lower than those made on a reasonable cost basis. Therefore, hospitals that exceed 500 procedures may have difficulty retaining access to nonphysician anesthetists' services because cost reimbursement is unavailable. According to data from the American Association of Nurse Anesthetists (AANA), the average total annual compensation for a CRNA in 2001 was approximately $155,000. The AANA estimates that, based on payments under the Medicare fee schedule, a CRNA would have to provide at least 800 anesthesia procedures to reach this average level of compensation.

The statute provides the Secretary with the authority to determine the appropriateness of the volume threshold, in part, so that changes necessary to meet the needs of rural hospitals can be made. As we have found that hospitals that exceed the 500 surgical procedures may have difficulty in retaining access to nonphysician anesthetists' services, we believe that the appropriate maximum threshold for surgical procedures should be raised in order for the payment exception to apply to those hospitals most in need of this payment treatment. Based upon the data available to us concerning the best

[3] We noted in the August 31, 1984 final rule that section 2312 and the Conference Report used the term ''CRNA'' throughout. However, we believed it was Congressional intent to apply this pass-through payment amount to the services of all qualified hospital-employed nonphysician anesthetists (49 FR 34748).

estimates of average total compensation to a CRNA, we believe that the maximum volume threshold for surgical procedures requiring anesthesia services should be raised to 800. Therefore, to ensure continued access to nonphysician anesthetists' services in rural hospitals, we are proposing to revise §§ 412.113(c)(2)(ii) and (c)(2)(iii) to raise the 500-procedure threshold to 800 procedures.

H. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§§ 412.230, 412.232, and 412.273)

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.

1. Withdrawals, Teminations, and Cancellations

Under § 412.273(a) of our regulations, 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 acute care hospital inpatient prospective payment system for the upcoming fiscal year (for example, this proposed rule for FY 2003). In the August 1, 2001 final rule, we specified that, for purposes of implementing section 304 of Public Law 106–554, the withdrawal procedures and the applicable timeframes in the existing regulations would apply to hospitals that receive 3-year reclassification for wage index purposes (66 FR 39886). Once effective, a withdrawal means that the hospital would not be reclassified for purposes of the wage index for FY 2003 (and would not receive continued reclassification for FYs 2004 and 2005), unless the hospital subsequently cancels its withdrawal.

Consistent with section 1886(d)(10)(D)(v) of the Act, a hospital may terminate its approved 3-year reclassification during the second or third years (§ 412.273(b)). This is a separate action from a reclassification withdrawal that occurs in accordance with the timeframes described above. Currently, in order to terminate an approved 3-year reclassification, we 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 hospital inpatient prospective payment system (§ 412.273(b)(1)(i)). A termination, unless subsequently cancelled, is effective for the full fiscal years remaining in the 3-year period.

We also provided that a hospital may apply for reclassification to a different area for the year corresponding to the second or third year of the reclassification (that is, an area different from the one to which it was originally reclassified) and, if successful, the reclassification would be for 3 years. Since the publication of the final rule, we received an inquiry regarding a situation where a hospital with an existing 3-year wage index reclassification successfully reclassifies to a different area, then withdraws from that second reclassification within the allowable timeframe for withdrawals. This scenario raises several issues not specifically addressed in the August 1, 2001 final rule, which we are proposing to clarify in this proposed rule.

For example, the question arises, at what point does a hospital's termination of a 3-year reclassification become effective when a hospital applies for reclassification to another area? As noted above, the August 1, 2001 final rule specified that a hospital must file a written request with the MGCRB within 45 days of publication of the annual proposed rule to terminate the reclassification. However, the rules do not specify at what point a previous 3-year reclassification is terminated when a hospital applies for reclassification to another area in subsequent years. One might conclude that an application for a wage index reclassification to another area constitutes a written notification of a hospital's intent to terminate an existing 3-year reclassification. Under this scenario, however, if the application to the second area were denied, it would then be necessary for the hospital to formally cancel the termination of its reclassification to the first area within 45 days of publication of the proposed rule to avoid a lapse in reclassification status the following year. Therefore, we are proposing to clarify, in § 412.273(b)(2)(iii), that, in a situation where a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1. In such a case, it will not be necessary for the hospital to submit a separate written notice of its intent to terminate its existing 3-year reclassification. Of course, a hospital also may still terminate an existing 3-year reclassification through written notice to the MGCRB, regardless of whether it successfully reclassifies to a different area.

The scenario of a hospital with an existing 3-year reclassification seeking reclassification to a second area raises another issue. If the hospital's request is approved by the MGCRB, but the hospital withdraws from that successful reclassification and ''falls back'' to its original 3-year reclassification, does the hospital retain the right to cancel that withdrawal the next year? In this way, a hospital could accumulate multiple reclassifications from which it could choose in any given year through canceling prior withdrawals or terminations to one area and withdrawing or terminating reclassifications to other areas.

We do not believe section 304 of Public Law 106–554 was intended to be used in such a manner. Therefore, we are proposing to clarify existing policy that a previous 3-year reclassification may not be reinstated after a subsequent 3-year reclassification to another area takes effect. This would mean that a hospital that is reclassified to an area for purposes of the wage index may have only one active 3-year reclassification at a time. Once a 3-year reclassification to a second area becomes effective, a previously terminated 3-year reclassification may not be reinstated by terminating or withdrawing the reclassification to the second area and then canceling the termination or withdrawal of the reclassification to the first area.

As we stated in the August 1, 2001 final rule, we believe the 3-year wage index reclassification policy was intended to provide consistency and predictability in hospital reclassifications and the wage index data. Allowing hospitals multiple reclassification options to choose from would create a situation where many hospitals move in unpredictable ways between the proposed and final rules based on their calculation of which of several areas would yield the highest wage index. This would reduce the predictability of the system, hampering the ability of the majority of hospitals to

adequately project their future revenues. Therefore, we are proposing to amend § 412.273(b)(2)(ii) to provide that, once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, even within 3 years from the date of such withdrawal or termination. We are also proposing a technical correction to § 412.273(b)(2)(i) to correct the terminology regarding canceling (rather than terminating) a withdrawal.

Finally, the August 1, 2001 final rule did not specifically describe the process to cancel a withdrawal or termination. Therefore, we are proposing to add a new § 412.273(d) (existing paragraph (d) would be redesignated as paragraph (e)) to describe the process whereby a hospital may cancel a previous withdrawal or termination of a 3-year wage index reclassification. Specifically, a hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for reclassifications effective at the start of the following fiscal year (§ 412.256(a)(2)).

2. Effect of Change of Ownership on Hospital Reclassifications

Sections 412.230(e)(2)(ii) and 412.232(d)(2)(ii) provide that, for reclassifications effective beginning FY 2003, a hospital must provide a 3-year average of its average hourly wages using wage survey data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

As discussed in the August 1, 2001 final rule, we received a comment suggesting that, for purposes of calculating the 3-year average hourly wages, we permit a hospital that has changed ownership the option of excluding prior years' wage data submitted by a previous owner in order for the new hospital to qualify for reclassification. Although we responded to the comment (66 FR 39890), we have now determined that there is a need to further clarify our policy regarding change of ownership and hospitals that do not accept assignment of the previous owner's provider agreement.

In our response to the comment, we stated that, where a hospital has simply changed ownership and the new owners have acquired the financial 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. Where this is not the case and there is no obligation on the part of the new hospital to claim the financial assets or assume the liabilities 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.

Section 489.18(c) provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner. Our regulations at § 412.230(e)(2) do not specifically address the situation of new hospitals seeking to reclassify for wage index purposes, in light of the requirement that reclassification is based on a 3-year average hourly wage. Therefore, we are proposing to revise § 412.230(e)(2), by adding a new paragraph (e)(2)(iii), to clarify our existing policy to specify that, in situations where a hospital does not accept assignment of the existing hospital's provider agreement under § 489.18, the hospital would be treated as a new hospital with a new provider number. In that case, 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. As we stated in the August 1, 2001 final rule, we believe this policy clarification is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. We are proposing to revise § 412.230 to clarify, under proposed new paragraph (e)(2)(iii), that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

I. 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 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 weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. 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 in FY 1994 or FY 1995 have two separate PRAs: 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)(D) 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. For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the floor PRA is 70 percent of the locality-adjusted, updated, weighted average PRA. For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, section 511 of Public Law 106–554 amended the floor PRA to equal 85 percent of the locality-adjusted, updated, weighted average PRA. PRAs that are below the applicable floor PRA for a particular cost reporting period would be adjusted to equal the floor 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. Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Determining the Weighted Average PRAs for Newly Participating Hospitals (§ 413.86(e)(5))

As stated earlier, under section 1886(h) of the Act and implementing regulations, in most cases Medicare pays hospitals for the direct costs of GME on the basis of per resident costs in a 1984 base year. However, under existing § 413.86(e)(5), if a hospital did not have residents in an approved residency training program, or did not participate in Medicare during the base period, the hospital's base period for its PRA is its first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. If there are at least three existing teaching hospitals with PRAs in the same geographic wage area (MSA), as that term is used in 42 CFR Part 412, the fiscal intermediary will calculate a PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same MSA. There must be at least three existing teaching hospitals with PRAs in the MSA for this calculation. If there are less than three existing teaching hospitals with PRAs within the new teaching hospital's MSA, effective for cost reporting periods beginning on or after October 1, 1997, the fiscal intermediary uses the updated regional weighted average PRA (determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes) for the new teaching hospital's MSA (see 62 FR 46004, August 29, 1997). A new teaching hospital is assigned a PRA equal to the lower of its actual allowable direct GME costs per resident or the weighted average PRA as calculated by the fiscal intermediary. Using a methodology based on a weighted average ensures that a new teaching hospital receives a PRA that is representative of the costs of training residents within its specific geographic wage area.

Under existing policy, to calculate the weighted average PRA of teaching hospitals within a particular MSA, the fiscal intermediary begins by determining the base year PRA and the base year FTE count of each respective teaching hospital within that MSA. The weighted average PRA is (a) the sum of the products of each existing teaching hospital's base year PRA in the MSA and its base year FTEs, (b) divided by the sum of the base year FTEs from each of those hospitals. While a methodology using base year PRAs and FTEs was appropriate and workable in the years closely following the implementation of hospital-specific PRAs, it has become administratively burdensome for both CMS and the fiscal intermediaries to recreate base year information in calculating a weighted average. The methodology is particularly problematic in instances where there are large numbers of teaching hospitals in an MSA.

In addition, as discussed in section V.I.1. of this proposed rule, hospitals that were training nonprimary care residents during FYs 1994 and 1995 have a distinct nonprimary care PRA, because there was no update in the inflation factor for these years (§ 413.86(e)(3)(ii)). Thus, most teaching hospitals currently have two PRAs: one for primary care and obstetrics and gynecology; and one for all other residents. (Hospitals that first train residents after FY 1995 only have a single PRA, regardless of whether they train primary care or other residents.) However, since the current methodology for calculating weighted average PRAs is based on data from FY 1984, which was prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents, the methodology does not account for *all* PRAs (both primary care and obstetrics and gynecology and nonprimary care) within an MSA.

Accordingly, we are proposing to simplify and revise the weighted average PRA methodology under § 413.86(e)(5)(i)(B) to reflect the average of all PRAs in an MSA, both primary care and obstetrics and gynecology, and nonprimary care. We would continue to calculate a weighted average PRA. However, rather than using 1984 base year data, we are proposing to use PRAs (both primary care and obstetrics and gynecology and nonprimary care) and FTE data from the most recently settled cost reports of teaching hospitals in an MSA. We are proposing that the intermediary would calculate the weighted average PRA using the following steps:

Step 1: Identify *all* teaching hospitals (including those serviced by another intermediary(ies)) in the same MSA as the new teaching hospital.

Step 2: Identify the respective primary care and obstetrics and gynecology FTE counts, the nonprimary care FTE counts, or the total FTE count (for hospitals with a single PRA) of each teaching hospital in step 1 from the most recently settled cost reports. (Use the FTE counts from line 3.07 and line 3.08 of the Medicare cost report, CMS–2552–96, Worksheet E–3, Part IV.)

Step 3: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA, or a hospital's single PRA) from the most recently settled cost reports of the hospitals in step 1, and update the PRAs using the CPI–U inflation factor to coincide with the fiscal year end of the new teaching hospital's base year cost reporting period. For example, if the base year fiscal year end of a new teaching hospital is December 31, 2003, and the most recently settled cost reports of the teaching hospitals within the MSA are from the fiscal year ending June 30, 2000, September 30, 2000, or December 31, 2000, the PRAs from these cost reports would be updated for inflation to December 31, 2003.

Step 4: Calculate the weighted average PRA using the PRAs and FTE counts from steps 2 and 3. For each hospital in the calculation:

(a) Multiply the primary care PRA by the primary care and obstetrics and gynecology FTEs.

(b) Multiply the nonprimary care PRA by the nonprimary care FTEs.

(c) For hospitals with a single PRA, multiply the single PRA by the hospital's total number of FTEs.

(d) Add the products from steps (a), (b), and (c) for all hospitals.

(e) Add the FTEs from step 3 for all hospitals.

(f) Divide the sum from step (d) by the sum from step (e). The result is the weighted average PRA for hospitals within an MSA.

The following is an example of how to calculate a weighted average PRA under the proposed methodology:

Example

Assume that new Hospital A has a June 30 fiscal year end and begins training residents for the first time on July 1, 2003. Thus, new Hospital A's base year for purposes of establishing a PRA is the fiscal year ending June 30, 2004. New Hospital A is located in MSA 1234, in which three other teaching hospitals exist, Hospital B, Hospital C, and Hospital D. These three hospitals also have a fiscal year end of June 30 and their most recently settled cost reports are for the fiscal year ending June 30, 2000. For fiscal year ending June 30, 2000, Hospital B has 200 primary care and obstetrics and gynecology FTEs, 150 nonprimary care FTEs, and 150 nonprimary care FTEs. Hospital C has 50 primary care and obstetrics and gynecology FTEs and 60

nonprimary care FTEs. Hospital D has 25 FTEs. After updating the PRAs for inflation by the CPI–U to June 30, 2004, Hospital B has a primary care and obstetrics and gynecology PRA of $120,000 and a nonprimary care PRA of $115,000, Hospital C has a primary care and obstetrics and gynecology PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital D has a single PRA of $90,000.

(a) Primary care:
Hospital B: $120,000 × 200 FTEs = $24,000,000
Hospital C: $100,000 × 50 FTEs = $5,000,000
(b) Nonprimary care:
Hospital B: $115,000 × 150 FTEs = $17,250,000
Hospital C: $97,000 × 60 FTEs = $5,820,000
(c) Single PRA:
Hospital D: $90,000 × 25 FTEs = $2,250,000
(d) $24,000,000 + 5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000.
(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs.
(f) $54,320,000/485 FTEs = $112,000, the weighted average PRA for MSA1234 for fiscal year ending June 30, 2004.

New Hospital A's PRA would be the lower of $112,000 or its actual base year GME costs per resident.

We are proposing that this new weighted average calculation would be effective for hospitals with direct GME base years that begin on or after October 1, 2002.

In addition, we are taking the opportunity to clarify the language under existing § 413.86(e)(5)(i)(B), which relates to calculating the weighted average under existing policy. Specifically, existing § 413.86(e)(5)(i)(B) states: ''The weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, *for cost reporting periods beginning in the same fiscal years* [emphasis added].'' We believe this language could be misinterpreted to imply that only those PRAs of hospitals in the same geographic wage area (MSA) *that have the same fiscal year end as the new teaching hospital* should be used in the weighted average calculation. However, the PRAs of *all* hospitals within the MSA of the new teaching hospital should be used, not just the PRAs of hospitals with the same fiscal year end as the new teaching hospital. The proposed revision appears under a proposed new § 413.86(e)(5)(i)(c).

3. Aggregate FTE Limit for Affiliated Groups (§§ 413.86 (b) and (g)(7))

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are member of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to permit hospitals flexibility in structuring rotations within a combined cap when they share residents' time. In accordance with the broad authority conferred by the statute, we created criteria for defining ''affiliated group'' and ''affiliation agreements'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). Because we have received many inquiries from the hospital industry on this policy, we are proposing to clarify in regulations the requirements for participating in an affiliated group. These requirements are explicitly derived from the policy explained in the August 29, 1997 and May 12, 1998 final rules.

Specifically, we are proposing to add under § 413.86(b) a new definition of ''Affiliation agreement.'' This new proposed definition would state that an affiliation agreement is a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group (as defined in § 413.86(b)), that specifies—

- The term of the agreement, which, at a minimum must be one year, beginning on July 1 of a year.
- Each participating hospital's direct and indirect FTE cap.
- The annual adjustment to each hospital's FTE caps, for both direct GME and IME. This adjustment must reflect the fact that any positive adjustment to one hospital's direct and indirect FTE caps must be offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount.
- The names of the participating hospitals and their Medicare provider numbers.

In addition, we are proposing to add a new § 413.86(g)(5)(iv) and a new § 413.86(g)(7) to clarify the requirements for a hospital to receive a temporary adjustment to its FTE cap through an affiliation agreement. (Existing § 413.86(g)(5)(iv) through (vi) are proposed to be redesignated as § 413.86(g)(5)(v) through (vii), respectively; and existing §§ 413.86(g)(7) through (g)(12) are proposed to be redesignated as §§ 413.86(g)(8) through (g)(13), respectively, to accommodate these additions.) Specifically, we are proposing that a hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules, to reflect residents added or subtracted because the hospital is participating in an affiliated group (as that term is defined under § 413.86(b)). Under this proposed provision—

- Each hospital in the affiliated group must submit the affiliation agreement (as that term is proposed to be defined under § 413.86(b)), to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.
- There must be a rotation of a resident(s) among the hospitals participating in the affiliated group during the term of the affiliation agreement, such that more than one of the hospitals counts the proportionate amount of the time spent by the resident(s) in their FTE resident counts. (However, no resident may be counted in the aggregate as more than one FTE.) This requirement is intended to ensure that the participating hospitals maintain a ''cross-training'' relationship during the term of the affiliation agreement.
- The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.
- If the affiliation agreement terminates for any reason, the FTE cap for each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap.

Except for the proposed new § 413.86(g)(7)(iv) regarding the treatment of FTE caps after termination of the affiliation agreement, each provision of proposed new § 413.86(g)(7) is explicitly derived from policy stated in the May 12, 1998 final rule (63 FR 26336). We are proposing to incorporate in regulations policy that was previously established under the formal rulemaking process.

We are proposing a change in policy concerning what happens to each participating affiliated hospital's FTE cap when an affiliation agreement terminates (proposed new § 413.86(g)(7)(iv)). In the preamble of the May 12, 1998 final rule (63 FR 26339), we stated: ''Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves, or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the

period of the agreement for purposes of applying the FTE cap on an aggregate basis. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the indirect and direct medical education FTE count from each hospital's cost reporting period ending in 1996 and the cap will not be applied on an aggregate basis.'' Our purpose for allowing hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of an affiliation was to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, in practice, very few hospitals have altered their FTE caps following termination of affiliation agreements. Rather, the vast majority of hospitals opted to revert to their respective 1996 FTE caps upon the termination of an affiliation. In addition, we have found that our existing policy is susceptible to the following abusive practice that does not comport with our original purpose for allowing redistribution of FTE caps among hospitals following termination of an affiliation agreement. We have learned of a number of instances in which one hospital (Hospital A) affiliated with another hospital (Hospital B) in anticipation of Hospital B's closure at some point during the residency program year. In these instances, the affiliation agreement was made solely for the purpose of obtaining a permanent adjustment to Hospital A's FTE cap through the terms of the termination clause. We do not believe these permanent FTE cap adjustments that result from hospital closures (or any other circumstances) were intended when Congress passed the provision on affiliation agreements. As stated above, we believe affiliations were meant to provide flexibility for hospitals in the rotations of residents where, in the normal course of an affiliation between two or more hospitals, the actual number of residents training at each hospital may vary somewhat from year to year. Affiliations were *not* intended to be used as a vehicle for circumventing the statutory FTE cap on the number of residents. In addition, we have separately addressed issues that arise when residents are displaced because of a pending hospital closure. We have in place a policy at existing § 413.86(g)(8) (proposed to be redesignated as § 413.86(g)(9) in this proposed rule) that permits *temporary* FTE cap adjustments for hospitals that take on the training of residents displaced by the closure of another hospital.

Therefore, we are proposing that, effective October 1, 2002, for hospitals with affiliation agreements that terminate (for any reason) on or after that date, the direct and indirect FTE caps for each hospital in the affiliated group will revert back to each individual hospital's original FTE cap prior to the affiliation (proposed new § 413.86(g)(7)(iv)). This policy would not preclude the participating hospitals from entering into additional affiliation agreements for later residency years.

Since this proposed policy would be effective for agreements that terminate on or after October 1, 2002, hospitals that have already received a permanent FTE cap adjustment from their fiscal intermediaries through the existing termination clause policy would retain those cap adjustments.

We also are proposing to make a conforming clarification at § 412.105(f)(1)(vi) for purposes of IME payments.

4. Rotating Residents to Other Hospitals

At existing § 413.86(f), we state, in part, that a hospital may count residents training in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of *time worked at the hospital* to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Although these policies concerning the counting of the number of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions about whether residents can be counted by a hospital for the time during which the resident is rotated to other hospitals.

We would like to clarify that it is longstanding Medicare policy, based on language in both the regulations and the statute, to prohibit one hospital from claiming the FTEs training at another hospital for IME and direct GME payment. This policy applies even when the hospital that proposes to count the FTE resident(s) actually incurs the costs of training the residents(s) (such as salary and other training costs) at another hospital.

First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME 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.'' In the September 4, 1990 **Federal Register** (55 FR 36064), we stated that '' * * * regardless of which teaching hospital employs a resident who rotates among hospitals, each hospital would count the resident in proportion to the amount of time spent at its facility.'' Therefore, another hospital *cannot* count the time spent by residents training at another hospital. Only the hospital where the residents are actually training can count those FTEs for that portion of time. For example, if, during a cost reporting year, a resident spends 3 months training at Hospital A and 9 months training at Hospital B, Hospital A can only claim .25 FTE and Hospital B can only claim .75 FTE. Over the course of the entire cost reporting year, the resident would add up to 1.0 FTE.

We have been made aware of some instances where an urban hospital may incur all the training costs of residents while those residents train at a rural hospital, because the rural hospital may not have the resources or infrastructure to claim those costs and FTEs on a Medicare cost report. However, even in this scenario, the urban hospital is precluded from claiming any FTEs for the proportion of time spent in training at that rural hospital, or at any other hospital.

We note, however, that, consistent with the statutory provisions of section 1886(d)(5)(B)(iv) of the Act for IME payment and section 1886(h)(4)(E) of the Act for direct GME payment, a hospital may count the time residents spend training in a *nonhospital* setting if the hospital complies with the regulatory criteria at § 413.86(f)(4).

J. Responsibilities of Medicare-Participating Hospitals in Emergency Cases (EMTALA)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these patients, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867 of the Act sets forth requirements for medical screening examinations for medical conditions, as well as necessary stabilizing treatment or appropriate transfer. In addition, section 1867 of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire

about the individual's payment method or insurance status. Section 1867 of the Act also provides for the imposition of civil monetary penalties on hospitals and physicians responsible for the following: (a) Negligently failing to appropriately screen a patient seeking emergency medical care; (b) negligently failing to provide stabilizing treatment to an individual with an emergency medical condition; or (c) negligently transferring a patient in an inappropriate manner. (Section 1867(e)(4) of the Act defines ''transfer'' to include both transfers to other health care facilities and cases in which the patient is released from the care of the hospital without being moved to another health care facility.)

These provisions, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). As a result, many people initially referred to EMTALA as ''COBRA'' or the ''COBRA antidumping'' statute. Congress enacted these antidumping provisions in the Social Security Act because of its concern with an ''increasing number of reports'' that hospital emergency rooms were refusing to accept or treat patients with emergency conditions if the patients did not have insurance:

''* * * The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other situations, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

''There is some belief that this situation has worsened since the prospective payment system for hospitals became effective. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

''[Under the statute] [a]ll participating hospitals with emergency departments would be required to provide an appropriate medical screening examination for any individual who requests it (or has a request made on his behalf) to determine whether an emergency medical condition exists or if the patient is in active labor.'' (H.R. Rept. No. 99–241, Part 1, 99th Cong., 1st Sess. (1985), p. 27.)

The regulations implementing section 1867 of the Act are found at 42 CFR 489.24, Special responsibilities of Medicare hospitals in emergency cases. Section 489.24 provides for the following:

- Paragraph (a) requires that when an individual presents to a hospital's emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.
- Paragraph (b) provides the definitions of terms, including ''comes to the emergency department,'' ''emergency medical condition,'' ''stabilized,'' and ''to stabilize.''
- Paragraph (c) addresses procedures a hospital must follow when it determines that an emergency medical condition exists. If the hospital determines that an emergency medical condition exists, the hospital must provide for further medical examination and treatment as required to stabilize the patient. If the hospital does not have the capabilities to stabilize the patient, an appropriate transfer to another facility is permitted. A transfer is appropriate when the medical benefits of the transfer outweigh the medical risks of the transfer and other requirements, specified in the regulation at paragraph (d), are met. Also, the hospital may transfer an unstable patient who makes an informed written request. Paragraph (c) further states that a hospital may not delay an appropriate medical screening examination, or further examination or treatment, to inquire about the individual's payment method or insurance status.

In addition, § 489.24 addresses: (a) Restriction of a transfer until the individual is stabilized; (b) the responsibilities of the receiving hospital; (c) termination of the provider agreement for failure to comply with EMTALA requirements; and (d) matters concerning consultation with Peer Review Organizations (paragraphs (d) through (h), respectively).

Some EMTALA-related requirements are implemented under regulations at §§ 489.20(l), (m), (q), and (r)(1), (r)(2), and (r)(3). Those regulations deal with a hospital's obligations to report the receipt of patients that it has reason to believe may have been transferred inappropriately; to post signs in the emergency department describing a patient's rights to emergency treatment under section 1867 of the Act; and to maintain patient records, physician on-call lists, and emergency room logs. We are including this brief description for informational purposes but, because we are not proposing to change the regulations in § 489.20, they will not be discussed further in this document.

In promulgating these cited regulatory sections and in enforcing the provisions of EMTALA, we are aware of the necessary balance between the hospital's and a physician's legal duty to provide examination and treatment under the statute and the practical realities of the manner in which hospitals and medical staffs are organized and operated on a day-to-day basis, as well as proper mobilization of resources within hospitals in order to comply with these legal duties. Reports of overcrowding in hospital emergency departments are common in many parts of the country. Within the requirements of EMTALA, individuals should be treated at the appropriate site of care.

Hospitals and physicians have now had over 15 years of experience in organizing themselves to comply with the provisions of EMTALA. Throughout this section of this proposed rule relating to EMTALA, we solicit comments from hospitals, physicians, patients, and beneficiary groups on the proposed changes to the EMTALA policies.

2. Special Advisory Bulletin on EMTALA Obligations

On November 10, 1999, CMS (previously, HCFA) and the Office of the Inspector General (OIG) published jointly in the **Federal Register** a Special Advisory Bulletin addressing the requirements of the patient antidumping statute and the obligations of hospitals to medically screen all patients seeking emergency services and provide stabilizing medical treatment as necessary to all patients, including enrollees of managed care plans, whose conditions warrant it (64 FR 61353). The Special Advisory Bulletin addressed issues of dual staffing of hospital emergency rooms by managed care and nonmanaged care physicians, prior authorization requirements of some managed care plans, use of advance beneficiary notices (ABNs) or other financial responsibility forms, handling of individuals' inquiries about financial liability for emergency services, and voluntary withdrawal of a treatment request. Although it does not amend the Code of Federal Regulations, the Special Advisory Bulletin informs individuals of HHS policy regarding application of the patient antidumping statute and offers advice on the best practices to follow to avoid violation of the requirements imposed under that statute.

As discussed further in section V.J.4. of this preamble, we are now proposing to codify certain policies on prior authorization that are currently stated only in the Special Advisory Bulletin. We believe these changes in the regulations are needed to ensure uniform and consistent application of policy and to avoid any misunderstanding of EMTALA requirements by patients, physicians, or hospital employees.

3. EMTALA Provisions in This Proposed Rule

Recently, a number of questions have been raised about the applicability of § 489.24 to specific situations. These questions arise in the context of managed care plans' requirements for prior authorization, case experiences involving elective procedures, and situations when patients have been admitted as inpatients but are not stabilized, or later experience a deterioration in their medical condition. Some hospitals are uncertain whether various conditions of participation found in 42 CFR part 482 apply to these situations or whether the EMTALA requirements included in the provider agreement regulations at § 489.24 apply, or both. Some representatives of the provider community have asked us to reexamine CMS policy on the applicability of EMTALA to provider-based departments. Finally, there have also been questions concerning the applicability of EMTALA to physicians who are ''on call'' and to hospitals that own ambulances when those ambulances operate under communitywide emergency medical services (EMS) protocols. To help promote consistent application of the regulations concerning the special responsibilities of Medicare hospitals in emergency cases, we are proposing changes to § 489.24 to clarify its application to these situations and at the same time address concerns about EMTALA raised by the Secretary's Advisory Committee on Regulatory Reform. These changes are discussed more fully below and include the following:

- We are proposing to change the requirements relating to emergency patients presenting at those off-campus outpatient clinics that do not routinely provide emergency services. We believe these changes would enhance the quality and promptness of emergency care by permitting individuals to be referred to appropriately equipped emergency facilities close to such clinics.
- We are proposing to clarify when EMTALA applies to both inpatients and outpatients. We believe these clarifications would enhance overall patient access to emergency services by helping to relieve administrative burdens on frequently overcrowded emergency departments.
- We are proposing to clarify the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff ''on-call'' lists. We expect these clarifications would help improve access to physician services for all hospital patients by permitting hospitals local flexibility to determine how best to maximize their available physician resources. We are currently aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals, especially when those physicians belong to more than one hospital medical staff. Physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. Our proposed clarification of the on-call list requirement would permit hospitals to continue to attract physicians to serve on their medical staffs and thereby continue to provide services to emergency room patients.
- We are proposing to clarify the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with citywide and local community EMS procedures for responding to medical emergencies and thus use these resources more efficiently for the benefit of these communities.

We solicit comments on all of these proposed changes.

4. Prior Authorization

Some managed care plans may seek to pay hospitals for services only if the hospitals obtain approval from the plan for the services before providing the services. Requirements for this approval are frequently referred to as ''prior authorization'' requirements. However, EMTALA (specifically, section 1867(h) of the Act and our regulation at § 489.24(c)(3)) explicitly prohibit hospitals from delaying screening or stabilization services in order to inquire about the individual's method of payment or insurance status. Thus, prior authorization requirements are a matter of concern because hospitals could, in seeking prior authorization from an insurer, present a barrier to or delay in the provision of services required by EMTALA.

After review of these considerations, we believe that our existing policy will best implement the intent of the statute by prohibiting a participating hospital from seeking authorization from the individual's insurance company for screening services or services required to stabilize an emergency medical condition until after the hospital has provided the appropriate medical screening examination required by EMTALA to the patient and has initiated any further medical examination and treatment that may be required to stabilize the patient's emergency medical condition.

We are soliciting comments as to whether the regulations should be further revised to state that the hospital may seek other information (apart from information about payment) from the insurer about the individual, and may seek authorization for all services concurrently with providing any stabilizing treatment, as long as doing so does not delay required screening and stabilization services.

In addition, we are proposing to specify that an emergency physician is not precluded from contacting the patient's physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient, as long as this consultation does not inappropriately delay required screening or stabilization services.

As explained earlier, this policy was stated in a Special Advisory Bulletin published jointly by CMS (then HCFA) and the OIG. However, we are now proposing to clarify existing language at § 489.24(c)(3) (proposed to be redesignated as paragraph (d)(4)) in this proposed rule to include this policy in the regulations.

5. Hospital Responsibility for Communication With Medicare+Choice Organizations Concerning Post-Stabilization Care Services

Section 422.113 of our existing regulations establishes rules concerning the responsibility of Medicare+Choice organizations for emergency and post-stabilization care services provided to Medicare+Choice enrollees (65 FR 40170, June 29, 2000). Under § 422.113(c)(2), a Medicare+Choice organization is financially responsible for post-stabilization care under certain circumstances, including situations in which the organization cannot be contacted or does not respond timely to a hospital's request for preapproval of this care.

It has come to our attention that, in some instances, hospitals may have failed to contact Medicare+Choice organizations on a timely basis to seek authorization for post-stabilization services. In such a case, the Medicare+Choice organization does not

have the opportunity provided for under the regulations to decide whether to approve the provision of post-stabilization services at the hospital where the emergency services were provided, or to require that the enrollee instead be transferred to another hospital for such services. Therefore, we are proposing to add a new paragraph (d)(6) under § 489.24 to specify that a hospital must promptly contact the Medicare+Choice organization after a Medicare+Choice enrollee who is treated for an emergency medical condition is stabilized.

6. Clarification of ''Comes to the Emergency Department''

Section 1867(a) of the Act and our regulations at § 489.24(a) provide, in part, that if any individual comes to the emergency department of a hospital and a request is made on that individual's behalf for examination or treatment of a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department. If the hospital determines that such an individual has an emergency medical condition, the hospital is further obligated to provide either necessary stabilizing treatment or an appropriate transfer. Occasionally, questions have arisen as to whether these EMTALA requirements apply to situations in which a patient comes to a hospital, but does not present to the hospital's emergency department. We are proposing to clarify under what circumstances a hospital is obligated under EMTALA to screen, stabilize, or transfer an individual who comes to a hospital, presenting either at its dedicated emergency department, as proposed to be defined below, or elsewhere on hospital property, seeking examination or treatment.

Sometimes individuals come to hospitals seeking examination or treatment for medical conditions that could be emergency medical conditions, but present for examination or treatment at areas of the hospital other than the emergency department. For example, a woman in labor may go directly to the labor and delivery department of a hospital or a psychiatric outpatient experiencing a psychiatric crisis may present at the psychiatry department. In the June 22, 1994 final rule (59 FR 32098), we defined ''comes to the emergency department'' at § 489.24(b) to clarify that a hospital's EMTALA obligations are triggered whenever an individual presents on hospital property in this manner in an attempt to gain access to the hospital for emergency care and requests examination or treatment for an emergency medical condition. At the time we adopted this interpretation of ''comes to the emergency department,'' we explained:

''We believe that section 1867 of the Act also applies to all individuals who attempt to gain access to the hospital for emergency care. An individual may not be denied services simply because the person failed to actually enter the facility's designated emergency department.'' (59 FR 32098)

We repeated this standard for situations in which a hospital becomes bound to meet EMTALA's screening and stabilization or transfer requirements with respect to individuals who present on hospital property in an attempt to gain access to the hospital for emergency care, but outside of a hospital's emergency department, in interpretative guidelines published in the State Operations Manual:

''If an individual arrives at a hospital and is not technically in the emergency department, but is on the premises (including the parking lot, sidewalk and driveway) of the hospital and requests emergency care, he or she is entitled to a medical screening examination.'' (State Operations Manual Appendix V—Responsibilities of Medicare Participating Hospitals in Emergency Cases, V–16)

Thus, an individual can ''come to the emergency department,'' creating an EMTALA obligation on the part of the hospital, in one of two ways: The individual can present at a hospital's dedicated emergency department (as proposed to be defined below) and request examination or treatment for a medical condition; or the individual can present elsewhere on hospital property in an attempt to gain access to the hospital for emergency care (that is, at a location that is on hospital property but is not part of a dedicated emergency department), and request examination or treatment for what may be an emergency medical condition.

Because of the need to clarify the applicability of EMTALA to a particular individual depending on where he or she presents on hospital property in order to obtain emergency care, we are proposing to define ''dedicated emergency department.'' ''Dedicated emergency department'' would mean a specially equipped and staffed area of the hospital that is used a significant portion of the time for the initial evaluation and treatment of outpatients for emergency medical conditions, as defined in § 489.24(b), and is either located: (1) On the main hospital campus; or (2) off the main hospital campus and is treated by Medicare under § 413.65(b) as a department of the hospital. The EMTALA statute was intended to apply to individuals presenting to a hospital for emergency care services. Accordingly, we believe it is irrelevant whether the dedicated emergency department is located on or off the hospital main campus, as long as the individual is presenting to ''a hospital'' for those services. Therefore, we are proposing in our definition of ''dedicated emergency department'' that such a department may be located on the main hospital campus, or it may be a department of the hospital located off the main campus. (We note that this proposed definition would encompass not only what is generally thought of as a hospital's ''emergency room,'' but would also include other departments of hospitals, such as labor and delivery departments and psychiatric units of hospitals, that provide emergency or labor and delivery services, or both, or other departments that are held out to the public as an appropriate place to come for medical services on an urgent, nonappointment basis.)

We are soliciting public comment on whether this proposed definition should more explicitly define what is a ''dedicated emergency department.'' Specifically, we are seeking comment on whether a ''significant portion of the time'' should be defined more objectively; for example, in terms of some minimum number or minimum percentage of patients (20, 30, 40 percent or more of all patients seen) presenting for emergency care at a particular area of the hospital in order for it to qualify as a ''dedicated emergency department.'' As an alternative, we could also consider a qualifying criteria that is based on determining whether the facility is used ''regularly'' for the evaluation or treatment of emergency medical conditions. Similarly, we are seeking comments on how we could define ''regularly'' more objectively in our consideration of this alternative. We further seek comments from hospitals, physicians, and others on how hospitals currently organize themselves to react to situations in which individuals come to a hospital requesting a screening examination or medical treatment, or both.

This proposed rule would clarify for hospitals that they must provide at least a medical screening examination to all individuals who present to an area of a hospital meeting the definition of dedicated emergency department and request examination or treatment for a medical condition, or have such a request made on their behalf. As we explain in section V.J.7. of this preamble, individuals who present to an

area of a hospital other than a dedicated emergency department on hospital property must receive a medical screening examination under EMTALA, only when the individual requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf, as provided in the proposed changes to § 489.24(b) in this proposed rule.

7. Applicability of EMTALA: Individual Comes to the Dedicated Emergency Department for Nonemergency Services

We sometimes receive questions as to whether EMTALA's requirements apply to situations in which an individual comes to a hospital's dedicated emergency department, but no request is made on the individual's behalf for emergency medical evaluation or treatment. In view of the specific language of section 1867 of the Act and the discussion in section V.J.6. of this proposed rule, which proposes to define a hospital's dedicated emergency department as a specially equipped and staffed area of the hospital that is used a significant portion of the time for the initial evaluation and treatment of outpatients for emergency medical conditions located on the main hospital campus or at an off-campus department of the hospital, we believe that a hospital must be seen as having an EMTALA obligation with respect to any individual who comes to the dedicated emergency department, if a request is made on the individual's behalf for examination or treatment for a medical condition, whether or not the treatment requested is explicitly for an emergency condition. A request on behalf of the individual would be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition. This does not mean, of course, that all EMTALA screenings must be equally extensive. The statute plainly states that the objective of the appropriate medical screening examination is to determine whether or not an emergency medical condition exists. Therefore, hospitals are not obligated to provide screening services beyond those needed to determine that there is no emergency.

In general, a medical screening examination is the process required to reach, with reasonable clinical confidence, a determination about whether a medical emergency does or does not exist. We expect that in most cases in which a request is made for medical care that clearly is unlikely to involve an emergency condition, an individual's statement that he or she is not seeking emergency care, together with brief questioning by qualified medical personnel, would be sufficient to establish that there is no emergency condition and that the hospital's EMTALA obligation would thereby be satisfied.

To clarify our policy in this area, we are proposing to redesignate paragraphs (c) through (h) of § 489.24 as paragraphs (d) through (i) (we are proposing to remove existing paragraph (i), as explained in section V.J.10. of this preamble) and to add a new paragraph (c) to state that if an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an ''emergency medical condition'' as defined in paragraph (b). (See example 1 below.)

Example 1: A woman walks up to the front desk of a hospital's emergency room, a dedicated emergency department, and tells the hospital employee attending the front desk that she had a wound sutured several days earlier and was directed by her doctor to have the sutures removed that day. The front desk attendant registers the woman according to the hospital's normal registration procedure and directs the woman to the waiting area. An emergency nurse, who has been designated by the hospital as a ''qualified medical person'' (as provided for in existing § 489.24(a)), calls the woman into the examination area of the emergency room. The nurse asks the woman if she has experienced any discomfort or noticed any problems in the area sutured. The woman explains that she is feeling fine, and the wound is not causing her any discomfort, but that her doctor had directed her a week ago to have the sutures removed that day. The nurse physically inspects the sutures and determines that the wound is healing appropriately. The nurse explains to the woman that she does not have an emergency medical condition and may direct the woman to an outpatient clinic where nonemergency personnel will provide the services the woman has requested.

Application: In this case, the woman presented at the hospital's dedicated emergency department and requested examination or treatment for a medical condition—specifically, she asked that her sutures be removed. Therefore, the hospital is bound under section 1867(a) of the Act to provide her a medical screening examination in order to determine whether or not she has an emergency medical condition. The actions of the nurse, ''a qualified medical person,'' constitute an appropriate medical screening examination under EMTALA because the nurse has determined, with reasonable clinical confidence, that the woman has no emergency medical condition. This appropriate medical screening examination fully satisfies the hospital's EMTALA obligations as to that woman; because the screening examination revealed no emergency medical condition, the hospital properly referred the woman to an outpatient clinic for nonemergency care.

8. Applicability of EMTALA: Individual Presents at an Area of the Hospital on the Hospital's Main Campus Other Than the Dedicated Emergency Department

Routinely, individuals come to hospitals as outpatients for many nonemergency medical purposes, and if such an individual initially presents at an on-campus area of the hospital other than a dedicated emergency department, we would expect that the individual typically would not be seeking emergency care. Under most of these circumstances, EMTALA would therefore not apply (this concept is further discussed in section V.J.8. of this preamble). A hospital would, however, incur an EMTALA obligation with respect to an individual presenting at that area who requests examination or treatment for what may be an emergency medical condition, or had such a request made on his or her behalf. This policy would not require that an emergency medical condition be found, upon subsequent medical examination, to exist. Rather, EMTALA is triggered in on-campus areas of the hospital other than a dedicated emergency department where, in an attempt to gain access to the hospital for emergency care, an individual comes to a hospital and requests an examination or treatment for a medical condition that may be an emergency.

We are proposing to specify in the regulations that such a request would be considered to exist if the individual requests examination or treatment for what the individual believes to be an emergency medical condition. Where there is no actual request because, for example, the individual is unaccompanied and is physically incapable of making a request, the request from the individual would be considered to exist if a prudent layperson observer would believe, based upon the individual's appearance or behavior, that the individual needs emergency examination or treatment. We believe this proposed policy is appropriate because it would not be

consistent with the intent of section 1867 of the Act to deny its protections to those individuals whose need for emergency services arises upon arrival on hospital on-campus property at the hospital's main campus but have not been presented to the dedicated emergency department.

Under the proposed policies discussed above, a request for examination or treatment by an individual presenting for what may be an emergency medical condition at an on-campus area of the hospital other than the dedicated emergency department would not have to be expressed verbally in all cases, but in some cases should be inferred from what a prudent layperson observer would conclude from an individual's appearance or behavior. While there may be a request (either through the individual or a prudent layperson), thereby triggering an EMTALA obligation on the part of the hospital, this policy does not mean that the hospital must maintain emergency medical screening or treatment capabilities in each department or at each door of the hospital, nor anywhere else on hospital property other than the dedicated emergency department. If an individual presents at an on-campus area of the hospital other than the dedicated emergency department in an attempt to gain access to the hospital for emergency care, EMTALA would mandate that the hospital (as a whole) would provide for screening and stabilizing the individual. For example, upon presentation of an individual requesting emergency care, if the department to which the individual presents cannot readily provide screening and, if needed, stabilization services, the department may arrange for appropriate staff to provide these services. Care required to be provided under EMTALA should be provided in the most appropriate setting, as determined by the hospital.

Example 2: An individual bleeding profusely from a severe scalp laceration enters a hospital through the main entry for hospital visitors, and says to one of the receptionists: ''I need help.'' The receptionist sees that the individual's head is bleeding and, noting his request, arranges to have the individual taken to the dedicated emergency department. Minutes later, the staff from the emergency department arrive and transport the individual to the hospital's emergency department to complete the screening and to give any necessary stabilizing treatment.

Application: The individual presented at an on-campus area of the hospital other than the dedicated emergency department (in this case, the main entry for hospital visitors), with his head bleeding profusely, asking for help. The receptionist, a prudent layperson observing the individual, believed that the individual was seeking emergency examination or treatment, thereby triggering an EMTALA obligation on the part of the hospital. (We note that EMTALA would have been triggered even if no verbal request had been made, since the individual's appearance indicated the clear possibility of an emergency medical condition.) Since the main entry for hospital visitors did not have emergency examination or treatment capabilities, the receptionist appropriately called the hospital's emergency department to summon emergency department staff to provide emergency care for that individual. Once the emergency department staff arrived and transported the individual to the hospital's emergency department, and provided him with the emergency care needed and stabilized the individual, the hospital had satisfied its EMTALA obligation to that individual.

Again, we solicit comments from hospitals and physicians that give examples of ways in which hospitals presently react to situations such as for the example noted above.

Most individuals who come to hospitals as outpatients come for many nonemergency purposes; under most circumstances, EMTALA would not apply. We are proposing that EMTALA would not apply to such an individual who then experiences what may be an emergency medical condition if the individual is an outpatient (as that term is defined at 42 CFR § 410.2) who has come to the hospital outpatient department for the purpose of keeping a previously scheduled appointment. We would consider such an individual to be an outpatient if he or she has begun an encounter (as that term is defined at § 410.2) with a health professional at the outpatient department. Because such individuals are patients of the hospital already, that is, they have a previously established relationship with the hospital, and have come to the hospital for previously scheduled medical appointments, we believe it is inappropriate that they be considered to have ''come to the hospital'' for purposes of EMTALA. However, we note that such an outpatient under this proposal who experiences what may be an emergency medical condition after the start of an encounter with a health professional would have all protections afforded to patients of a hospital under the Medicare hospital conditions of participation (as discussed in section V.J.13. of this proposed rule). Hospitals that fail to provide treatment to these patients could face termination of their Medicare provider agreements for a violation of the conditions of participation. In addition, as patients of a health care provider, these individuals are accorded protections under State statutes or common law as well as under general rules of ethics governing the medical professions.

Example 3: A patient who had been discharged from inpatient status following knee replacement surgery comes to the hospital outpatient department for a physical therapy session which had been scheduled 2 weeks earlier. While undergoing therapy, the patient complains of chest pains and lightheadedness. Acting under protocols established by the hospital, staff of the outpatient department contact the hospital's dedicated emergency department, which dispatches appropriate personnel to the department. The patient is taken to the hospital's dedicated emergency department for examination. Upon arrival in the dedicated emergency department, she is given a medical screening examination, which reveals that she has an emergency medical condition related to coronary artery disease. She is stabilized in the dedicated emergency department and is released to the care of her daughter.

Application: In this case, the individual is an outpatient. While she is in a physical therapy session in an outpatient department of the hospital, she experiences what may be an emergency medical condition—chest pains and lightheadedness. This outpatient is under the care of the hospital; she is in a previously scheduled physical therapy appointment and clearly has a previously established relationship with the hospital. In addition, the encounter with hospital staff has begun since her condition arose while she was undergoing therapy. Therefore, although the individual may be experiencing what may be an emergency medical condition, the hospital is not obligated under EMTALA. However, the hospital appropriately provided treatment for this patient, as required under the Medicare conditions of participation (specifically, 42 CFR § 482.55, which requires the hospital to fulfill its condition of participation responsibility for emergency care by contacting the hospital's dedicated emergency department and providing care to the individual through staff of that department). We solicit comments from hospitals and physicians as to what current practices are when an outpatient with a previously scheduled appointment experiences an emergency medical condition.

We are proposing to retitle the definition of ''property'' at § 489.24(b) to ''hospital property'' and relocate it as a

separate definition. In addition, we are proposing to clarify which areas and facilities are not considered hospital property.

9. Scope of EMTALA Applicability to Hospital Inpatients

While most issues regarding EMTALA arise in connection with ambulatory patients, questions have occasionally been raised about whether EMTALA applies to inpatients. In late 1998, the United States Supreme Court considered a case (*Roberts* v. *Galen of Virginia*) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Supreme Court that the Department of Health and Human Services (DHHS) would develop a regulation clarifying its position on that issue. After reviewing the issue in the light of the EMTALA statute, we are proposing that EMTALA would apply to inpatients only under limited circumstances, as described in the following paragraphs.

As noted earlier, once a hospital has incurred an EMTALA obligation with respect to an individual, that obligation continues while the individual remains at the hospital, so that any transfer to another medical facility or discharge of the individual must be in compliance with the rules restricting transfer until the individual is stabilized under existing § 489.24(d). In many cases, medical judgment will dictate that a patient be admitted to the hospital for further treatment on an inpatient basis because the patient's emergency medical condition has not yet been stabilized.

In these cases, the hospital continues to be obligated under section 1867, irrespective of the inpatient admission. Admitting an individual whose emergency medical condition has not been stabilized does not relieve the hospital of further responsibility to the individual under this section. An individual's emergency medical condition will be considered to have been stabilized only when the criteria in § 489.24(b) are met; that is, the individual's condition must be such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer of the individual from the facility or, if the patient is a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

Consistent with the above policy, we emphasize that an admission to inpatient status cannot be used to evade EMTALA responsibilities. Indeed, permitting inpatient admission to end EMTALA obligations would provide an obvious means of circumventing these requirements that would seemingly contradict the point of the statute to protect emergency patient health and safety. This point should be particularly evident in the case of a woman in labor, a central focus of the statute. Such women are frequently admitted, and the statute clearly contemplated protecting them until completion of the delivery (that is, stabilization). In addition, if an inpatient who had been admitted from the dedicated emergency department with an unstabilized emergency medical condition was never stabilized as an inpatient and is transferred, we would still apply EMTALA in reviewing the transfer. In this context, stability for transfer reflects a complex medical judgment that can be made only based on review of all relevant information in each particular case, including all conditions that could cause the patient to be medically unstable. A patient who goes in and out of apparent stability with sufficient rapidity or frequency would not be considered ''stabilized'' within the meaning of § 489.24; transient stability of such a patient does not relieve the hospital of its EMTALA obligation. Such a patient would continue to be covered by EMTALA until the patient's overall medical stability with respect to all conditions is achieved.

Except for the limited circumstances described above, we are proposing to clarify that EMTALA does not apply to hospital inpatients. We believe EMTALA does not apply to hospital inpatients because we interpret section 1867 of the Act by reading the statutory language as a whole, with the requirements of paragraphs (b), ''Necessary Stabilizing Treatment for Emergency Medical Conditions and Labor,'' and (c), ''Restricting Transfer Until Individual is Stabilized,'' applying only to those individuals who satisfy the threshold requirement of coming to the hospital and requesting emergency care (as interpreted in this proposed regulation). This interpretation is based upon the statutory language and the legislative history. First, the Congress defined ''emergency medical condition'' at section 1867(e)(1) of the Act by referring solely to ''acute symptoms,'' which are self-identified, and did not mention other potentially relevant indications, in particular, signs or objective data. ''Signs'' are observable findings that are identified or confirmed by a clinician based on examination and use of objective data (for example, physiologic measurements, x-ray results). When a patient's condition deteriorates in the inpatient setting, awareness of a situation potentially requiring emergency care is based on any symptoms, signs, and objective data, reflecting a situation that is not captured by the targeted definition at section 1867(e)(1) of the Act. If the Congress had intended EMTALA to apply to transfers at any time during an inpatient stay, it would not have used a definition of emergency medical condition that focuses exclusively on symptoms and that uniquely defines the individual's status at the time of his or her initial presentation to the hospital, not his or her status as an inpatient. Furthermore, the definition of ''appropriate transfer'' in paragraph (c)(2) of section 1867 of the Act includes a variety of terms (observation, signs, symptoms, preliminary diagnosis) associated with patient information that is gathered at the initial stage of clinical intervention, when the course of treatment is just beginning. Thus, it would appear to be clear that the authors of this legislation understood the precise meanings of these clinical terms and utilized them accordingly. Further indication that Congress intended this result is the language in section 1867(b)(1)(A) of the Act (stabilization), which requires that the hospital provide ''for such further medical examination'' as necessary to stabilize. Congress' use of the word ''further'' acknowledges that there was some initial treatment that occurred in the emergency department.

In addition, the legislative history of EMTALA is replete with references to the problem of individuals denied emergency medical care at hospital emergency rooms, whereas there is no explicit reference to similar problems faced by hospital inpatients. (*See,* for example, 131 Cong. Rec. 28.587 and 28.588 (1985)). When the Congress considered the need for EMTALA legislation, it noted that Medicare-participating hospitals were bound to meet hospital conditions of participation, but that no specific requirements then existed for appropriate treatment of emergency patients. (*See* H.R. Rept. No. 241 (I)(1985), reprinted in 1986 U.S.C.C.A.N. 579, 605.) Arguably, the Congress also considered other protections available to hospital inpatients (for example, private causes of action).

This interpretation that EMTALA was not intended to apply to transfers at any time during an inpatient's stay is further supported by the language of the appropriate transfer provisions of section 1867(c) of the Act. While that paragraph does refer to individuals at a

''hospital,'' rather than individuals at an ''emergency department,'' the same paragraph also makes reference to actions to be taken by ''a physician * * * physically present in the emergency department.'' This explicit mention of a hospital emergency department, even in a paragraph that generally cites an individual at a ''hospital,'' supports the view that EMTALA was not intended to apply to admitted inpatients who may become unstable subsequent to admission, but only to patients who initially come to the hospital's emergency department with an emergency medical condition, and only until the condition has been stabilized. Finally, we note that once a hospital admits an individual as a patient, that hospital has a variety of other legal, licensing, and professional obligations with respect to the continued proper care and treatment of such patients.

a. Admitted Emergency Patients. A related issue concerns whether a hospital may satisfy its EMTALA obligations to an admitted emergency inpatient only by effectuating an actual stable discharge or appropriate transfer. We are proposing to clarify that even when an admitted emergency patient is not actually transferred, a determination may be made as to whether or not the patient has been stabilized such that he or she could be transferred at a certain point without likely material deterioration of the patient's condition, as defined in section 1867(e)(3)(B) of the Act. Under our proposed policy, if the admitted emergency patient could have been transferred as ''stable'' under the statute and the period of stability is documented by relevant clinical data in the patient's medical record, the hospital has satisfied its EMTALA obligation by meeting the statutory requirement of providing stabilizing treatment to the point of stability for transfer, and the hospital's obligation under EMTALA ends, even though the patient may remain in inpatient status at the hospital. If, after stabilization, the individual who was admitted as an inpatient again has an apparent decline of his or her medical condition, either as a result of the injury or illness that created the emergency for which he or she initially came to the dedicated emergency department or as a result of another injury or illness, the hospital must comply with the conditions of participation under 42 CFR Part 482, but has no further responsibility under EMTALA with respect to the individual.

We also note that, just because a hospital may stabilize a patient for purposes of ending its EMTALA obligation to that patient, this does not relieve the hospital of any further health and safety obligations as to that patient under the Medicare program. While they remain patients in that hospital, these patients are still protected by a number of Medicare health and safety standards (conditions of participation), as explained further below. In addition, as explained above, nothing under EMTALA in any way changes a hospital's other legal, licensing, and professional obligations with respect to the continued proper care and treatment of its patients.

Example 4: A patient comes to Hospital C's emergency department and requests treatment for an emergency medical condition. The patient knows he has severe heart disease and his chest pains have become more frequent. The patient receives an appropriate medical screening examination and is found to have an emergency medical condition, as indicated by a pain pattern and EKG abnormalities consistent with unstable angina. Stabilizing treatment in the emergency department on an outpatient basis, consisting of oxygen, nitrates and heparin, is initiated.

After several hours of outpatient care, the emergency physician determines that the patient is still not stable for purposes of discharge to his home. The emergency physician concludes that the patient can be treated most effectively by being admitted to Hospital C where he is currently being treated as an outpatient. The patient is admitted as an inpatient for further treatment. The attending physician knows that patients with indications for coronary angioplasty are usually transferred to Hospital D in another city because Hospital D has specialized capabilities that are unavailable at admitting Hospital C. A trip to Hospital D typically requires 2 hours travel by ground ambulance. The physician determines that the patient is stable for purposes of this type of transfer; that is, such a transfer is not likely to result in a material deterioration of the patient's condition, and documents relevant clinical data in the patient's medical record. Even though patients with this degree of coronary arterial disease and acute infarction risk are usually transferred, the patient opposes transfer and wants to remain in the local community. In accordance with the wishes of the patient and his family, the attending physician agrees to treat the patient in Hospital C while informing the patient of the risks involved.

Application: In this situation, the admitted patient is not stable for purposes of discharge to his home but the attending physician determined that the patient is stable for the type of transfer usually undertaken by Hospital C for patients with unstable angina considered for angioplasty. This stabilization, which is documented by relevant clinical data in the patient's medical record, ends Hospital C's EMTALA obligation to the patient, and that obligation would not be reinstated by any subsequent deterioration in the patient's condition.

We are proposing to redesignate paragraph (c) of § 489.24 as paragraph (d), and include these stabilization requirements under a new proposed § 489.2(d)(2). (Proposed redesignated paragraph (d) would be revised further as explained in section V.K.9.b. of this preamble.)

b. Admitted Elective (Nonemergency) Patients. Most hospital admissions do not consist of emergency cases. In most cases, a patient who comes to the hospital and requests admission does so to obtain elective (nonemergency) diagnosis or treatment for a medical condition. Questions have arisen, however, as to whether a hospital would be bound under EMTALA in the situation in which an admitted nonemergency inpatient experiences a deterioration of his or her medical condition.

Under our interpretation of section 1867 of the Act as described above, we believe EMTALA was intended to provide protection to patients coming to a hospital to seek care for an emergency condition. Therefore, we believe that the EMTALA requirements do not extend to admitted nonemergency inpatients. These patients are protected by a number of the Medicare hospital conditions of participation, as explained further under section V.K.13. of this preamble. These patients are further protected by a hospital's other legal, licensing, and professional obligations with respect to the continued proper care and treatment of its patients.

We are proposing to also include these requirements under the proposed redesignated § 489.24(d)(2).

10. Applicability of EMTALA to Provider-Based Entities

On April 7, 2000, we published a final rule specifying the criteria that must be met for a determination regarding provider-based status (65 FR 18504). The regulations in that the April 2000 final rule were subsequently revised to incorporate changes mandated by section 404 of Public Law 106–554 (66 FR 59856, November 30, 2001). However, those revisions did not substantively affect hospitals' obligations with respect to off-campus departments.

a. Applicability of EMTALA to Off-Campus Hospital Departments. In the April 7, 2000 final rule (65 FR 18504), we also clarified the applicability of EMTALA to hospital departments not located on the main provider campus. At that time, we revised § 489.24 to include a new paragraph (i) to specify the antidumping obligations of hospitals

with respect to individuals who come to off-campus hospital departments for the examination or treatment of a potential emergency medical condition. As explained in the preamble to the April 7, 2000 final rule, we made this change because we believed it was consistent with the intent of section 1867 of the Act to protect individuals who present on hospital property (including off-campus hospital property) for emergency medical treatment. Since publication of the April 7, 2000 final rule, it has become clear that many hospitals and physicians continue to have significant concerns with our policy on the applicability of EMTALA to these off-campus locations. After further consideration, we are proposing to clarify the scope of EMTALA's applicability in this scenario to those off-campus departments that are treated by Medicare under § 413.65(b) to be departments of the hospital, and that are equipped and staffed areas that are used a significant portion of the time for the initial evaluation and treatment of outpatients for emergency medical conditions. That is, we are proposing to narrow the applicability of EMTALA to only those off-campus departments that are ''dedicated emergency departments'' as defined in proposed revised § 489.24(b).

This proposed definition would include such departments whether or not the words ''emergency room'' or ''emergency department'' were used by the hospital to identify the departments. The definition would also be interpreted to encompass those off-campus hospital departments that would be perceived by a prudent layperson as appropriate places to go for emergency care. Therefore, we are proposing to revise the definition of ''Hospital with an emergency department'' at § 489.24(b) to account for these off-campus dedicated emergency departments and to also amend the definition of ''Comes to the emergency department'' at § 489.24(b) to include this same language. We believe this proposed change would enhance the quality of emergency care by facilitating the prompt delivery of emergency care in those cases, thus permitting individuals to be referred to nearby facilities with the capacity to offer appropriate emergency care.

In general, we expect that off-campus departments that meet the proposed definitions stated above would in practice be functioning as ''off-campus emergency departments.'' Therefore, we believe it is reasonable to expect the hospital to assume, with respect to these off-campus departments, all EMTALA obligations that the hospital must assume with respect to the main hospital campus emergency department. For instance, the screening and stabilization or transfer requirements described in section V.K.1. of this preamble (''Background'') would extend to the off-campus emergency departments, as well as to any such departments on the main hospital campus.

In conjunction with this proposed change in the extent of EMTALA applicability with respect to off-campus facilities, we are also proposing to delete all of existing § 489.24(i), which, as noted above, was established in the April 7, 2000 final rule. We are proposing to delete this paragraph in its entirety because its primary purpose is to describe a hospital's EMTALA obligations with respect to patients presenting to off-campus departments that do not routinely provide emergency care. Under the proposals outlined above, however, a hospital would have no EMTALA obligation with respect to individuals presenting to such departments. Therefore, it would no longer be necessary to impose the requirements in existing § 489.24(i). Even though off-campus provider-based departments that do not routinely offer services for emergency medical conditions would not be subject to EMTALA, some individuals may occasionally come to them to seek emergency care. Under such circumstances, we believe it would be appropriate for the department to call an emergency medical service (EMS) if it is incapable of treating the patient, and to furnish whatever assistance it can to the individual while awaiting the arrival of EMS personnel. Consistent with the hospital's obligation to the community and similar to our requirements under § 482.12(f)(2) that apply to hospitals that do not provide emergency services, we would expect the hospital to have appropriate protocols in place for dealing with individuals who come to off-campus nonemergency facilities to seek emergency care. To clarify a hospital's responsibility in this regard, we are proposing to revise § 482.12(f) by adding a new paragraph (3) to state that if emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff of the hospital has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate. (We note that, in a separate document (62 FR 66758, December 16, 1997), we proposed to relocate the existing § 482.12(f) requirement to a new section of Part 482. Any change to the existing § 482.12(f) that is adopted as a result of the proposal described above will be taken into account in finalizing the December 19, 1997 proposal.) However, the hospital would not incur an EMTALA obligation with respect to the individual.

In summary, we are proposing in existing § 489.24(b) to revise the definitions of ''comes to the emergency department'' and ''hospital with an emergency department'', and to include these off-campus departments in our new definition of ''dedicated emergency department.'' We welcome comments on whether this new term is needed or if the term ''emergency department'' could be defined more broadly to encompass other departments that provide urgent or emergent care services. We are proposing to delete all of existing § 489.24(i) and to make conforming revisions to § 413.65(g)(1).

b. On-Campus Provider-Based Applicability. At existing § 413.65(g)(1), we state, in part, that if any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, the entity must comply with the antidumping rules at § 489.24. Since provider-based entities, as defined in § 413.65(b), are not under the certification and provider number of the main provider hospital, this language, read literally, would appear to impose EMTALA obligations on providers other than hospitals, a result that would not be consistent with section 1867, which restricts EMTALA applicability to hospitals. To avoid confusion on this point and to prevent any inadvertent extension of EMTALA requirements outside the hospital setting, we are proposing to clarify that EMTALA applies in this scenario to only those *departments* on the hospital's main campus that are provider-based; EMTALA would not apply to provider-based *entities* (such as RHCs) that are on the hospital campus.

In addition, we are proposing in § 489.24(b) to revise the definition of ''Comes to the emergency department'' to include an individual who presents on hospital property, in which ''hospital property'' is in part defined as ''the entire main hospital campus as defined at § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures that may be located within 250 yards of the hospital's main building but are not part of the hospital, such as physician offices, RHCs, SNFs, or other entities

that participate separately in Medicare, or restaurants, shops, or other nonmedical facilities.'' We are specifically seeking comments on this proposed revised definition. Generally, this proposed language would clarify that EMTALA does not apply to provider-based entities, whether or not they are located on a hospital campus. This language is also consistent with our policy as stated in questions and answers published on the CMS website: *www.cms.gov* (CMS EMTALA guidance, 7/20/01, Q/A # 1) that clarifies that EMTALA does not apply to other areas or structures located on the hospital campus that are not part of the hospital, such as fast food restaurants or independent medical practices.

If this proposed change limiting EMTALA applicability to only those on-campus departments of the hospital becomes finalized, we believe that if an individual comes to an on-campus provider-based entity or other area or structure on the campus not applicable under the new policy and presents for emergency care, it would be appropriate for the entity to call the emergency medical service if it is incapable of treating the patient, and to render whatever assistance it can to the individual while awaiting the arrival of emergency medical service personnel. However, the hospital on whose campus the entity is located would not incur an EMTALA obligation with respect to the individual.

We welcome comments from providers and other interested parties on the proper or best way to organize hospital resources to react to situations on campus where an individual patient or prospective patient requires immediate medical attention.

We are proposing in § 489.24(b) to revise the definition of ''Comes to emergency department'' (specifically, under proposed new paragraph (1)) and make conforming changes at § 413.65(g)(1).

11. EMTALA and On-Call Requirements

We have frequently received inquiries concerning the applicability of EMTALA for physicians on call. We believe there are a number of misconceptions in the provider industry concerning the extent to which EMTALA requires physicians to provide on-call coverage. Therefore, we are including a section in this preamble that clarifies what kinds of obligations physicians have to provide on-call coverage under EMTALA.

Section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that hospitals must keep a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If a physician on the list is called by a hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Act.

The CMS State Operations Manual (SOM) further clarifies a hospital's responsibility for the on-call physician. The SOM (Appendix V, page V–15, Tag A404) states:

- Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.
- Physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

Thus, hospitals are required to maintain a list of physicians on call at any one time and physicians or hospitals, or both, may be responsible under the EMTALA statute to provide emergency care if a physician who is on the on-call list fails to or refuses to appear within a reasonable period of time. However, Medicare does not set requirements on how frequently a hospital's staff of on-call physicians are expected to be available to provide on-call coverage. We are aware that practice demands in treating other patients, conferences, vacations, days off, and other similar factors must be considered in determining the availability of staff. We also are aware that some hospitals, particularly those in rural areas, have stated that they incur relatively high costs of compensating physician groups for providing on-call coverage to their emergency departments, and that doing so can strain their already limited financial resources. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.

We understand that some hospitals exempt senior medical staff physicians from being on call. This exemption is typically written into the hospital's medical staff bylaws or the hospital's rules and regulations, and recognizes a physician's active years of service (20 or more years) or age (that is, 60 years of age or older), or a combination of both. We wish to clarify that providing such exemptions to members of hospitals' medical staff does not necessarily violate EMTALA. On the contrary, we believe that the hospital is responsible for maintaining an on-call list in a manner that best meets the needs of its patients as long as the exemption does not affect patient care adversely. Thus, CMS allows hospitals flexibility in the utilization of their emergency personnel.

We also note that there is no predetermined ''ratio'' that CMS uses to identify how many days that a hospital must provide medical staff on-call coverage based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24 hour/7 day coverage. Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond.

Example 5: Hospital D has 75 beds and is located in a rural area. The hospital provides on-call coverage of orthopedic services on all weekdays and the first 3 weekends of each month. On the fourth weekend of one month, an individual presents at Hospital D's dedicated emergency department and requests examination for a medical condition. The emergency physician on duty screens the individual and finds that she has an orthopedic emergency medical condition requiring the services of an orthopedist. Hospital D does not have on-call orthopedic physician coverage on this date and, therefore, transfers the individual to an urban hospital 20 miles away for necessary treatment. The transfer is arranged in accordance with procedures that Hospital D has for meeting patient needs when a particular specialty is not available or the physician cannot respond for reasons beyond his or her control.

Analysis: Hospital D incurred an EMTALA obligation when the individual presented at Hospital D's dedicated emergency department and requested examination for a medical condition. At that time, Hospital D did not have on-call coverage to provide necessary stabilizing treatment for what was an orthopedic emergency medical condition, even though an orthopedic physician was on-call at other times. The emergency physician at Hospital D weighed the risks involved to transfer the individual to an urban hospital with capabilities to treat the individual and found that it would be more beneficial to the individual to transfer him or her

to the urban hospital 20 miles away, than to provide screening and stabilizing treatment within Hospital D's capabilities (which, at that time, did not include orthopedic services). Hospital D has satisfied its EMTALA obligation by providing screening services within its capability, followed by an appropriate transfer, under procedures developed in advance. To clarify our policies on EMTALA requirements regarding the availability of on-call physicians, we are proposing to add to § 489.24 a new paragraph (j) to specify that each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. This paragraph would further specify that physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times, and that the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

12. EMTALA Applicability to Hospital-Owned Ambulances

We stated in the June 22, 1994 final rule (59 FR 32098) that if an individual is in an ambulance owned and operated by a hospital, the individual is considered to have come to the hospital's emergency department, even if the ambulance is not on hospital property. This policy, currently set forth at § 489.24(b), was necessary because we were concerned that some hospitals that owned and operated ambulances at that time were transporting individuals who had called for an ambulance to other hospitals, thereby evading their EMTALA responsibilities to the individuals.

Concerns have since been raised by the provider industry about applications of this policy to ambulances that are owned by hospitals but are operating under communitywide EMS protocols that may require the hospital-owned and other ambulances to transport individuals to locations other than the hospitals that own the ambulances. For instance, we understand that some community protocols require ambulances to transport individuals to the nearest hospital to the patient geographically, whether or not that hospital owns the ambulance.

To avoid imposing requirements that are inconsistent with local EMS requirements, we are proposing to clarify, at proposed revised § 489.24(b) in the definition of ''Comes to the emergency department'', an exception to our existing rule requiring EMTALA applicability to hospitals that own and operate ambulances. Our proposal would account for hospital-owned ambulances operating under communitywide EMS protocols. Under our proposal, the rule on hospital-owned ambulances and EMTALA does not apply if the ambulance is operating under a communitywide EMS protocol that requires it to transport the individual to a hospital other than the hospital that owns the ambulance. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property.

13. Conditions of Participation for Hospitals

We are reminding hospitals and others that while this proposed regulation would make it clear that stabilizing an emergency inpatient relieves the hospital of its EMTALA obligations, it does not relieve the hospital of all further responsibility for the patient who is admitted or indicate that the hospital is thus free to improperly discharge or transfer him or her to another facility. Inpatients who experience acute medical conditions receive protections under the hospital conditions of participation, which are found at 42 CFR part 482. In addition, as noted earlier in this preamble, we believe that outpatients who experience what may be an emergency medical condition after the start of an encounter with a health professional would have all protections afforded to patients of a hospital under the Medicare conditions of participation. There are six conditions of participation that provide these protections: emergency services, governing body, discharge planning, quality assurance, medical staff, and outpatient services. We are not proposing in this proposed rule to make changes to any of the conditions of participation.

If a hospital inpatient develops an acute medical condition and the hospital is one that provides emergency services, the hospital is required to ensure that it meets the emergency needs of the patient in accordance with accepted standards of practice. Similarly, regardless of whether the hospital provides emergency services, if an inpatient develops an acute medical condition, the governing body condition of participation (§ 482.12(f)(2), which applies to all Medicare-participating hospitals) would apply. This condition of participation requires that the hospital governing body must ensure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

The discharge planning condition of participation (§ 482.43, which applies to all Medicare-participating hospitals) requires hospitals to have a discharge planning process that applies to all patients. This condition of participation ensures that patient needs are identified and that transfers and referrals reflecting adequate discharge planning are made by the hospital. If an inpatient develops an acute medical condition and the hospital either does not offer emergency services or does not have the capability to provide necessary treatment, a transfer to another hospital with the capabilities to treat the emergency medical condition could be warranted. Hospitals are required to meet the discharge planning condition of participation in carrying out such a transfer.

The hospital condition of participation governing medical staff (§ 482.22) requires that the hospital have an organized medical staff that operates under bylaws approved by the governing body and is responsible to the governing body for the quality of medical care provided to patients by the hospital. Should the medical staff not be held accountable to the governing body for problems regarding a lack of provision of care to an inpatient who develops an emergency medical condition, this lack of accountability may be reviewed under the medical staff condition of participation, as well, and may result in a citation of noncompliance at the medical staff condition level for the hospital.

Finally, the quality assurance condition of participation (§ 482.21, which applies to all Medicare-participating hospitals) requires the governing body to ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of patient care. In order to comply with this condition of participation, the hospital must evaluate the care it provides hospital-wide. Complaints regarding a lack of provision of care to an inpatient who develops an emergency medical condition must be addressed under the hospital's quality assurance program and may be reviewed under the quality assurance condition of participation.

A hospital's failure to meet the conditions of participation requirements cited above may result in a finding of noncompliance at the condition level for the hospital and lead to termination of the hospital's Medicare provider agreement.

K. Provider-Based Entities

1. Background

a. The April 7, 2000 Final Rule

Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

In the April 7, 2000 **Federal Register** (65 FR 18504), we published a final rule specifying the criteria that must be met for a determination regarding provider-based status. The regulations at § 413.65(a)(2) define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' The regulations at existing § 413.65(b)(2) state that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally October 10, 2000, but was subsequently delayed and is now in effect for new facilities or organizations for cost reporting periods beginning on or after January 10, 2001, as explained further below. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual, Part 1 (PRM–1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in section V.K.3. of this preamble).

b. Frequently Asked Questions Regarding Provider-Based Issues

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS website at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting any of the CMS (formerly, HCFA) Regional Offices.) These questions and answers did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

c. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

(1) Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000, will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria in the existing regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations are not exempt from the EMTALA responsibilities of provider-based facilities and organizations set forth at § 489.24, which we are proposing to revise as discussed above, or from the other obligations of hospital outpatient departments and hospital-based entities in existing § 413.65(g), such as the responsibility of off-campus facilities to provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not preempted by the grandfathering provisions of section 404 of BIPA because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

(2) Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the existing regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or CAH. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under existing § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria will continue indefinitely. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering

provision noted above, the geographic location criteria at section 404(b) of BIPA and the existing regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. On October 1, 2002, the statutory moratorium on application of these criteria to the grandfathered facilities will expire. In this proposed rule, we are proposing a further delay, as discussed below.

(3) Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA also provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000, and before October 1, 2002, shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively once a request for a determination during that time period has been made. For hospitals that do not qualify for grandfathering under section 404(a) of BIPA, a request for provider-based status should be submitted to the appropriate CMS Regional Office. Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based until the effective date of a CMS determination that the facility or organization is not provider-based.

Facilities requesting a provider-based status determination on or after October 1, 2002, will not be covered by the provision concerning temporary treatment as provider-based in section 404(c) of BIPA. Thus, as stated in § 413.65(n), the CMS Regional Offices will make provider-based status effective as of the earliest date on which a request for determination has been made and all requirements for provider-based status in effect as of the date of the request are shown to have been met, not on the date of the formal CMS determination. Under existing regulations at § 413.65(j), if a facility or organization does not qualify for provider-based status and CMS learns that the provider has treated the facility or organization as provider-based without having obtained a provider-based determination under applicable regulations, CMS will review all payments and may seek recovery for overpayments, including overpayments made for the period of time between submission of the request or application for provider-based status and the issuance of a formal CMS determination. (As explained in the previous paragraph, such retroactive recovery of payments would not be made for any period to the extent it is prohibited by section 404(c) of BIPA.)

d. The August 24, 2001 and November 30, 2001 Published Regulations

In August 24, 2001 **Federal Register** (66 FR 44672), we proposed to revise the provider-based regulations to reflect the changes mandated by section 404 of BIPA and to make other technical and clarifying changes in those regulations. In the November 30, 2001 **Federal Register** (66 FR 59856), following consideration of public comments received on the August 24, 2001 proposal, we published a final rule that revised the provider-based regulations. However, the only substantive changes in the provider-based regulations were those required by the BIPA legislation.

2. Proposed Changes

In the preamble to the proposed rule published on August 24, 2001 (66 FR 44709), we stated our intent to reexamine the EMTALA regulations and, in particular, to reconsider the appropriateness of applying EMTALA to off-campus locations. We announced that we planned to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. We also pointed out that, at the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole.

In addition, since the statutory grandfathering provision in the BIPA legislation remains in effect only until October 1, 2002, many hospital representatives have contacted CMS to request more guidance because they are concerned that their facilities are not in compliance with existing regulations and would not be able to continue billing as provider-based once the grandfathering provision expires. These hospital representatives are also concerned that the organizational and contractual changes needed to meet current provider-based requirements could take several months to complete. Moreover, resolution of some of the issues surrounding the provider-based regulations is needed in order to allow development of a uniform application form to enable the CMS Regional Offices to efficiently process the multitudes of requests for provider-based determinations that we expected as the grandfathering period expires.

To address the provider-based issues raised by the hospital industry and to allow for an orderly and uniform implementation strategy once grandfathering ends, we are proposing the following regulatory changes:

a. Scope of Provider-Based Requirements (§ 413.65(a))

Since publication of the April 2000 final rule, we have received many questions about which specific facilities or organizations are subject to the provider-based requirements. In the ''Frequently Asked Questions'' posted on the CMS website, we identified a number of facility types for which provider-based determinations would not be made, since such determinations would not affect either Medicare payment or Medicare beneficiary liability or scope of benefits. The regulations at § 413.65(a) were further revised to incorporate the exclusion of these facility types from review under the provider-based criteria. We now are proposing to further revise § 413.65(a)(1)(ii) to state that provider-based determinations will not be made with respect to independent diagnostic testing facilities that furnish only services paid under a fee schedule, such as facilities that furnish only screening mammography services, as defined in section 1861(jj) of the Act, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services. A provider-based determination would not be appropriate for a facility that furnishes only screening mammography because of a change made by section 104 of BIPA. That legislation, which amended section 1848(j)(3) of the Act, mandates that all payment for screening mammography services furnished on or after January 1, 2000, be made under the Medicare Physician Fee Schedule (MPFS). Under the MPFS methodology, Medicare payment for the service, regardless of the setting in which it is furnished, is set at the lesser of the fee schedule amount or the actual charge; and no Part B deductible applies. Regardless of the setting, Part B coinsurance is assessed at 20 percent of the lesser of the fee schedule amount or the actual charge. Because the status of a facility as provider-based or freestanding would

not affect the amount of Medicare or Medicaid payment, the beneficiary's scope of benefits, or the beneficiary's liability for coinsurance or deductible amounts, it is not necessary to make a provider-based determination regarding facilities that furnish only screening mammography. We are also proposing to revise § 413.65(a)(1)(ii) by adding a new paragraph (J) to state that we will not make provider-based determinations with respect to departments of providers (for example, laundry or medical records departments) that do not furnish types of health care services for which separate payment could be claimed under Medicare or Medicaid. (Such services frequently are referred to as ''billable'' services.) As explained more fully below, we would not make determinations with respect to these departments because their status (that is, whether they are provider-based or not) would have no impact on Medicare or Medicaid payment or on the scope of benefits or beneficiary liability under either program.

Despite the previous clarifications described above, providers, associations, and their representatives have continued to state that they are confused as to which facilities or organizations will be the subject of provider-based determinations.

In this document, we are proposing to further clarify the types of facilities that are subject to the provider-based rules, by making several changes to the definitions of key terms in § 413.65(a)(2). First, we are proposing to revise the definition of ''department of a provider'' to remove the reference to a physician office as being a department of a provider. While a hospital outpatient department, in fact, may furnish services that are clinically indistinguishable from those of physician offices, physician offices and provider departments are paid through separate methods under Medicare and beneficiaries may be liable for different coinsurance amounts. Thus, it is essential to distinguish between these facility types, and we believe avoiding confusion on this issue requires us to remove the reference to a hospital department as a physician office.

We also are proposing to revise § 413.65(a)(2) to state that a ''department of a provider'', ''provider-based entity'', or ''remote location of a hospital'' comprises both the specific physical facility that serves as the site of services of a type for which separate payment could be claimed under the Medicare or Medicaid programs, and the personnel and equipment needed to deliver the services at that facility. We believe this change would help to clarify that we would make determinations with respect to entities considered in their role as sources of health care services and not simply as physical locations. We also wish to clarify that we do not intend to make provider-based determinations with respect to various organizational components or units of providers that may be designated as ''departments'' or ''organizations'' but do not themselves furnish types of services for which separate payment could be claimed under Medicare or Medicaid. Examples of components for which we would not make provider-based determinations include the medical records, housekeeping, and security departments of a hospital. Such departments do perform functions that are essential to the provision of inpatient and outpatient hospital services, but the departments do not provide health care services for which Medicare or Medicaid benefits are provided under title XVIII or title XIX of the Act, and for which separate payment therefore could be claimed, assuming certification and other applicable requirements were met, to one or both programs. Therefore, neither Medicare or Medicaid program liability nor beneficiary liability or scope of benefits would be affected by the ability or inability of these departments to qualify as ''provider-based.'' (We also would not make a provider-based determination with respect to any facility or organization that furnishes only types of health care services for which separate payment could be claimed under either Medicare or Medicaid, even if the facility or organization met all requirements for provider-based status. For example, if a hospital that is not eligible for DSH payments under Medicare or Medicaid or for IME payments under Medicare were to establish a dedicated facility providing only types of cosmetic surgery or experimental therapies that could not be covered under either Medicare or Medicaid, no determination would be made with respect to that facility.)

By contrast, Medicare or Medicaid payment (or both) to hospital departments that provide diagnostic or therapeutic radiology services to outpatients, or primary care, ophthalmology, or other specialty services to outpatients are affected by provider-based status, as would beneficiary liability for Medicare coinsurance amounts. Therefore, we would make provider-based determinations for these departments.

Similarly, if two acute care hospitals that have approved graduate medical education (GME) programs were to merge to form a single, multicampus hospital consisting of the main hospital campus and a remote location, it would be appropriate to make a determination as to whether the remote location is provider-based with respect to the main hospital campus. Such a determination would be needed because each hospital with an approved residency training program has its own hospital-specific cap on the number of residents (or FTE cap), its own PRA, and its own Medicare utilization used for purposes of receiving Medicare GME payments. A merger of the two hospitals would aggregate the two hospitals' individual FTE caps into a merged FTE cap under the main hospital's provider number, and would require recalculation of the hospital's PRA and a merging of these entities' respective Medicare utilization, resulting in a level of Medicare GME payment to the merged hospital that exceeds the sum of the payments that would be made to each hospital as separate entities. Thus, a provider-based determination would be appropriate and necessary in such a case, even though payment for services by both facilities would be made under the Medicare acute care hospital inpatient prospective payment system.

In deciding whether to make a provider-based determination with respect to a particular facility, it would not be significant that the facility might have a low rate of Medicare utilization, might be utilized by only Medicare or only Medicaid patients, or might not have admitted any Medicare or Medicaid patients in a particular period. The fact that the facility furnishes types of services that are billable under Medicare or Medicaid, or both, would be sufficient to make a determination appropriate.

We are proposing to retain the rules that a department of a provider or a remote location of a hospital (such as, for example, one campus of a multicampus hospital) may not by itself be qualified to participate in Medicare as a provider under the regulations on provider agreements in § 489.2, and the Medicare conditions of participation do not apply to a department as an independent entity. However, we are proposing to delete the requirement at § 413.65(a)(2) that such a department may not be licensed to provide services in its own right. Some States require separate licensing of facilities that Medicare would treat as a department of a hospital or other provider. In these States, we would not require a common license. We would retain the provision that, for purposes of Part 413, the term ''department of a provider'' does not

include an RHC or, except as specified in § 413.65(m), an FQHC.

Questions have arisen regarding whether the provider-based criteria in § 413.65 are applicable in determining payment for ambulance services. Medicare is converting payment for ambulance services to a fee schedule, as described in a final rule published on February 27, 2002 (67 FR 9100). The ambulance fee schedule is effective April 1, 2001, and involves a transition period. During this transition period, the status of an ambulance supplier as provider-based could influence the amount of Medicare payment. However, the specific provider-based criteria in § 413.65 were not developed for ambulance suppliers, and we believe that many of these criteria could not reasonably be applied to them. Therefore, we are not proposing to apply the criteria at § 413.65 to ambulance services.

b. Further Delay in Effective Date of Provider-Based Rules

As noted earlier, § 413.65(b) was recently revised to reflect the ''grandfathering'' provision in section 404(a)(1) of BIPA. Under that provision, if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002.

It now appears likely that any new provider-based rules that may be adopted as the result of this rulemaking effort will not be published in final before mid-summer of 2002. To allow hospitals and other facilities the time they need to make contractual and organizational changes to comply with the new rules, and to ensure that CMS Regional Offices and contractors are able to provide for an orderly transition to the new provider-based rules, we believe an additional delay in the effective date of the provider-based criteria is needed. Therefore, we are proposing to revise § 413.65(b)(2) to state that if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. We are proposing to further provide that the requirements, limitations, and exclusions specified in § 413.65(d) through (j) (as proposed to be redesignated) will not apply to that hospital or CAH for that facility until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. For purposes of paragraph (b)(2), a facility would be considered as having been provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital. We are proposing to make the new requirements effective on October 1, 2002, with respect to provider-based status for facilities not qualifying for the grandfathering provision.

c. Revision of Application Requirement

Existing regulations at § 413.65(b)(2) establish an explicit application requirement for all facilities seeking provider-based status, except for grandfathered facilities and those treated as provider-based pending a determination on an application filed on or after October 1, 2000, and before October 1, 2002. Under existing § 413.65(b)(3), a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report. Many providers and provider representatives have expressed concern that the requirement to file an application will increase paperwork burden for hospitals unnecessarily. In response to these concerns, we are proposing to revise the application requirements as follows:

First, we would delete the existing application requirement under § 413.65(b)(3). We are proposing to revise this section to state that except where payment is required to be made under BIPA, as specified in proposed revised § 413.65(b)(2) and (b)(5), if a potential main provider seeks an advance determination of provider-based status for a facility that is located on the main campus of the potential main provider, the provider would be required to submit an attestation stating that its facility meets the criteria in § 413.65(d) and, if it is a hospital, also attest that its facility will fulfill the obligations of hospital outpatient departments and hospital-based entities, as described in proposed § 413.65(g). The provider also would be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS upon request. We note that, under our proposal, there would no longer be an explicit requirement that a provider-based approval be obtained before a facility is treated as provider-based for billing or cost reporting purposes. However, under the proposed revisions to existing § 413.65(k) (Correction of errors) as described below, CMS would provide a delay in the effective date for any facility that is found not to meet the provider-based criteria following a previous advance determination, if the reason the provider-based criteria are not met is a material change in the provider-facility relationship that was properly reported to CMS. The removal of provider-based status would be effective as of the first cost reporting period following notification of the redetermination, but not less than 6 months after the date of notification.

We are further proposing that if the facility is not located on the main campus of the potential main provider, the provider that wishes to obtain an advance determination of provider-based status would be required to submit an attestation stating that its facility meets the criteria in proposed revised §§ 413.65(d) and (e) and, if the facility is operated as a joint venture or under a management contract, the requirements in proposed §§ 413.65(f) and (h), as applicable. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in proposed revised § 413.65(g). The provider seeking such an advance determination would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations. We believe the use of a self-attestation process would strike an appropriate balance between the legitimate interests of hospitals in reducing paperwork and reporting, and the equally legitimate need of CMS to ensure proper accountability for compliance with the qualification requirements for a status that typically leads to a higher level of Medicare or Medicaid payment.

We note that, under these proposed revisions to the application procedures at § 413.65(b), a hospital would not be explicitly required to submit an application and receive a provider-based determination for a facility before the time at which the hospital may bill for services at that facility as provider-based. However, we are considering, alternatively, retaining the existing regulations at § 413.65(b)(2) which state that, except where payment is required to be made under BIPA as specified in proposed revised §§ 413.65(b)(2) and (b)(5), hospitals are explicitly required to submit provider-based applications, and to withhold billing as provider-based until CMS determines that a facility meets the provider-based rules. We are soliciting comments on the

appropriateness of this or other alternative application procedures.

d. Requirements Applicable to All Facilities or Organizations

Under existing § 413.65, all facilities seeking provider-based status with respect to a hospital or other main provider must meet a common set of requirements. These include requirements relating to common licensure (paragraph (d)(1)), operation under the ownership and control of the main provider (paragraph (d)(2)), administration and supervision (paragraph (d)(3)), integration of clinical services (d)(4)), financial integration (paragraph (d)(5)), public awareness (paragraph (d)(6)), and location in the immediate vicinity of the main provider (paragraph (d)(7)). (In addition, as described more fully below, specific rules applicable to all facilities rule out provider-based status for facilities operated as joint ventures by two or more providers (paragraph (e)) and limit the types of management contracts that facilities seeking provider-based status may operate under (paragraph (f)).)

Since publication in final of the existing provider-based rules in April 2000, hospitals and other providers have expressed concern that the requirements outlined above are overly restrictive and do not allow them enough flexibility to enter into appropriate business arrangements with other facilities. We understand these concerns, and agree that Medicare rules should not restrict legitimate business arrangements that do not lead to abusive practices or disadvantage Medicare beneficiaries. At the same time, we believe our existing rules provide a high level of assurance that a facility complying with them is, in fact, an integral and subordinate part of the facility with which it is based, and do not accord provider-based status to facilities that are not integral and subordinate to a main provider, but in fact have only a nominal relationship with that provider.

After considering all comments received on these issues, we believe that further changes in the provider-based rules would be appropriate. In particular, we agree with those who argue that a facility's or organization's location relative to the main campus of the provider is relevant to the integration that is likely to exist between the facility or organization and the main provider. For example, if a facility or organization is located on the main campus of a provider, is operated under the main provider's State license, is medically and financially integrated with that provider, and is held out to the public and other payers as a part of that provider, we believe the necessary degree of integration of the facility or organization into the main provider can be assumed to exist. We also are concerned that further prescribing the types of management contracts or other business arrangements that may exist between the main provider and the facility or organization would unnecessarily restrict its flexibility to establish cost-effective agreements without significantly enhancing the integration of the facility or organization into the main provider. Therefore, we are proposing to simplify the requirements applicable to facilities or organizations located on the campus of the main provider (as campus is defined in existing regulations at § 413.65(a)(2)). Under our proposal, all facilities seeking provider-based status, including both on-campus and off-campus facilities, would be required to comply with the existing requirements regarding licensure, clinical services integration, financial integration, and public awareness. (These requirements are currently codified at §§ 413.65(d)(1), (d)(4), (d)(5), and (d)(6) and, under this proposed rule, would be redesignated as paragraphs (d)(1) through (d)(4), respectively, of § 413.65.)

With respect to financial integration, existing regulations at § 413.65(d)(5) require that the financial operations of the facility or organization be fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The regulations also require that costs of a provider-based facility or organization be reported in a cost center of the provider, and that the financial status of any provider-based facility or organization be incorporated and readily identified in the main provider's trial balance.

Some hospital representatives have questioned the appropriateness of requiring that the costs of a remote location of a hospital be reported in a single cost center, noting that such costs ordinarily would appear in multiple cost centers of the main provider, with (for example) employee health and welfare costs of the remote location being included in the corresponding cost center of the main provider. In recognition of this concern, we are proposing to revise the requirement to state that the costs of a facility or organization that is a hospital department must be reported in a cost center of the provider, and that costs of a provider-based facility or organization other than a hospital department must be reported in the appropriate cost center or cost centers of the main provider.

Paragraph (d) of § 413.65 would be retitled ''Requirements applicable to all facilities or organizations'' and, as indicated by its revised title, would set forth those core requirements that any facility or organization would have to meet to qualify for provider-based status.

We are proposing to delete from this paragraph (d) the requirements in existing paragraphs (d)(2) and (d)(3) relating to operation under the ownership and control of the main provider and administration and supervision because we are proposing to no longer apply these requirements to on-campus facilities or organizations. These requirements would be moved to paragraph (e) as described below to reflect the proposed limitation of their applicability to off-campus departments. The core requirements for all facilities or organizations, including facilities located on the main campus, also would not include the requirement regarding location in the immediate vicinity of the main provider (existing § 413.65(d)(7)). Because any facilities or organizations located on the campus of the main provider automatically meet the requirement regarding location in the immediate vicinity (existing § 413.65(d)(7)), the requirement is only of relevance to off-campus facilities or organizations. For clarity, we are proposing to relocate the requirement to paragraph (e) as described below.

We also are proposing to require, in paragraph (d)(5) of § 413.65, all hospital outpatient departments and hospital-based entities, including those located on campus and those located off the campus of the main provider hospital, to fulfill the obligations currently codified and proposed to be retained at § 413.65(g) in order to qualify for provider-based status. (Fulfillment of these obligations is currently required under § 413.65(g).) As explained further below, we also are proposing other changes to paragraph (g).

e. Additional Requirements Applicable to Off-Campus Facilities or Organizations

We recognize that facilities or organizations located off the main provider campus may also be sufficiently integrated with the main provider to justify provider-based designation. However, the off-campus location of the facilities or organizations may make such integration harder to achieve, and such integration should not simply be presumed to exist. Therefore, to ensure that off-campus facilities or organizations seeking

provider-based status are appropriately integrated, we are proposing to retain for these facilities or organizations certain requirements that we are proposing to remove for on-campus facilities or organizations. These requirements are set forth in proposed new § 413.65(e). The requirements set forth in proposed paragraphs (e)(1), (e)(2), and (e)(3) include the requirements on operation under the ownership and control of the main provider (existing § 413.65(d)(2)), administration and supervision (existing § 413.65(d)(3)), and location (existing § 413.65(d)(7)). We also are proposing to include language in proposed new § 413.65(e) to state more clearly that a facility or organization seeking provider-based status must be located in the same State or, when consistent with the laws of both States, in adjacent States.

f. Joint Ventures

Consistent with our views as expressed earlier in this preamble regarding the assumption that a higher degree of integration can be presumed for on-campus facilities or organizations and in recognition of the need to promote reasonable cooperation among providers and avoid costly duplication of specialty services, we are proposing to revise the regulations on joint ventures (currently set forth under § 413.65(e)) to limit their scope to facilities or organizations not located on the campus of any potential main provider. Specifically, we would redesignate § 413.65(e) as § 413.65(f) and revise it to state that a facility or organization that is not located on the campus of the potential main provider cannot be considered provider-based if the facility or organization is owned by two or more providers engaged in a joint venture. We also are proposing to make minor changes to the second sentence of the redesignated paragraph (f) to clarify its meaning.

g. Clarification of Obligations of Hospital Outpatient Departments and Hospital-Based Entities

Existing regulations impose specific obligations for hospital outpatient departments and hospital-based entities, but do not specify the sanction that applies if the facility or organization does not fulfill its obligations. To clarify policy on this issue and emphasize the importance of compliance with the requirements in this area, we are proposing to revise existing § 413.65(g) to state that to qualify for provider-based status in relation to a hospital, a facility or organization must comply with these requirements. In regard to these obligations, we are proposing to make three changes in existing 413.65(g). First, for reasons explained in section V.J. of this preamble, we are proposing to revise paragraph (g)(1) by deleting the second sentence of that paragraph. In paragraph (g)(2), we are proposing to delete the reference to site-of-service reductions and instead refer to more accurately determined physician payment amounts, in order to more accurately describe how payment under the physician fee schedule is determined. In addition, we are proposing to revise the first sentence of paragraph (g)(7) to clarify that the notice requirements in it do not apply where a beneficiary is examined or treated for a medical condition in compliance with the antidumping rules in § 489.24. This clarification is needed because we believe it would be a violation of the antidumping requirements if examination or treatment required under § 489.24 was delayed in order to permit notification of the beneficiary or the beneficiary's authorized representative. We would further revise § 413.65(g)(7) to state that notice is required once the beneficiary has been appropriately screened and the existence of an emergency has been ruled out or the emergency condition has been stabilized.

h. Management Contracts

Under existing regulations, facilities or organizations operated under management contracts may be considered provider-based only if they meet specific requirements in § 413.65(f) (proposed to be redesignated as § 413.65(h)). In particular, staff of the facility or organization, other than management staff, may not be employed by the management company but must be employed either by the provider or by another organization, other than the main provider, which also employs the staff of the main provider. Under existing regulations, these requirements apply equally to on-campus and off-campus facilities or organizations.

Consistent with our intent to simplify provider-based requirements for on-campus facilities or organizations, we are proposing to restrict the applicability of proposed redesignated paragraph (h) to off-campus facilities or organizations. In addition, we are proposing two additional changes that we believe are needed to respond to questions that are raised frequently about the regulation. First, we would specify that a facility or organization operated under a management contract may be considered provider-based only if the main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at 42 CFR Part 414. We would not specify who may employ other support staff, such as maintenance or security personnel, and who are not directly involved in providing patient care, nor would we require licensed professional caregivers such as physicians, physician assistants, or certified registered nurse anesthetists to become provider employees. We also are proposing to revise the regulations to clarify at § 413.65(h)(2) that so-called ''leased'' employees (that is personnel who are actually employed by the management company but provide services for the provider under a staff leasing arrangement) are not considered to be employees of the provider for purposes of this provision.

i. Inappropriate Treatment of a Facility or Organization as Provider-Based

Below we describe the steps that we would take if we discover that a facility is billing as provider-based without having requested a determination, or if the facility received a provider-based determination but the main provider did not inform CMS of a subsequent material change that affected the provider-based status of its facility.

(1) Inappropriate Billing

The existing regulations at § 413.65(i) state that if we discover that a provider is billing inappropriately, we will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates should have been made in the absence of a determination of provider-based status. Existing § 413.65(j)(2) states that we would adjust future payments to approximate as closely as possible the amounts that would be paid, in the absence of a provider-based determination, if all other requirements for billing are met. In addition, existing § 413.65(j)(5) describes a procedure under which CMS would continue payments to a provider for services of a facility or organization that had been found not to be provider-based, at an adjusted rate calculated as described in existing paragraph (j)(2), for up to 6 months in order to permit the facility or organization adequate time to meet applicable enrollment and other billing requirements. While CMS is not legally obligated to continue payments in this matter, we believe it would be

appropriate to do so, on a time-limited basis, to allow for an orderly transition to either provider-based or freestanding status for the facility and to avoid disruption in the delivery of services to patients, particularly Medicare patients, who may be relying on the facility for their medical care.

We are proposing to adopt a policy concerning recoupment and continuation of payment that closely parallels the policy stated in existing regulations at § 413.65(j). Under proposed § 413.65(j)(1), if CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request an advance determination of provider-based status from CMS under proposed § 413.65(b)(3), and CMS determines that the facility or organization did not meet the requirements for provider-based status under proposed § 413.65(d) through (i), as applicable (or, in any period before the effective date of these regulations, the provider-based requirements in effect under Medicare program regulations or instructions), CMS would take several actions. First, we are proposing to issue notice to the provider, in accordance with proposed paragraph (j)(3), that payments for past cost reporting periods may be reviewed and recovered as described in proposed paragraph (j)(2)(ii), that future payments for services in or at the facility or organization will be adjusted as described in proposed paragraph (j)(4), and that continued payments to the provider for services of the facility or organization will be made only in accordance with proposed paragraph (j)(5). In addition, as detailed in proposed § 413.65(j)(1)(ii), CMS would, except for providers protected under section 404(a) or (c) of BIPA (implemented at § 413.65(b)(2) and (b)(5)) or the exception for good faith effort at existing § 413.65(i)(2) and (i)(3)), recover the difference between the amount of payments that actually was made to that provider for services at the facility or organization and an estimate of the payments that CMS would have made to that provider for services at the facility or organization in the absence of compliance with the requirements for provider-based status. We are proposing to make recovery for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889. Also, we are proposing to adjust future payments to approximate the amounts that would be paid for the same services furnished by a freestanding facility.

Recovery of past payments would be limited in certain circumstances. If a provider did not request a provider-based determination for a facility by October 1, 2002, but is included in the grandfathering period under § 413.65(b)(2), we are proposing to recoup all payments subject to the reopening rules at §§ 405.1885 and 405.1889, but not for any period before the provider's cost reporting period beginning on or after July 1, 2003.

(2) Good Faith Effort

We are proposing to retain the existing exception for good faith effort (proposed redesignated § 413.65(j)(2)). Under this exception, we would not recover any payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001 (the effective date of the existing provider-based regulations for providers not grandfathered under § 413.65(b)(2)) if during all of that period—

- The requirements regarding licensure and public awareness at § 413.65(d)(1) and proposed redesignated (d)(4) were met;
- All facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity of the main provider; and
- All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described at proposed redesignated and revised § 413.65(h)(2).

Under proposed § 413.65(j)(5), CMS would continue payment to a provider for services of a facility or organization for a limited period of time, in order to allow the facility or organization or its practitioners to meet necessary enrollment and other requirements for billing on a freestanding basis. Specifically, the notice of denial of provider-based status sent to the provider would ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, as to whether the provider intends to seek an advance determination of provider-based status for the facility or organization, or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services as a freestanding facility. If the provider indicates that it will not be seeking an advance determination or that the facility or organization or its practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payments under proposed paragraph (j)(5) would end as of the 30th day after the date of notice. If the provider indicates that it will be seeking an advance determination, or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization would continue, at the adjusted amount described in proposed paragraph (j)(4) for as long as is required for all billing requirements to be met (but not longer than 6 months). Continued payment would be allowed only if the provider or the facility or organization or its practitioners submits, as applicable, a complete request for an advance provider-based determination or a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization or its practitioners furnishes all other information needed by CMS to process the request for provider-based status or, as applicable, the enrollment application and verify that other billing requirements are met. If the necessary applications or information are not provided, CMS would terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

j. Temporary Treatment as Provider-Based and Correction of Errors

Under proposed revised § 413.65(k), we would specify the procedures for payment for the period between the time a request is submitted until a provider-based determination is made, and the steps we would take if we discover that a facility for which a provider previously received a provider-based determination no longer meets the requirements for provider-based status.

First, we are proposing that, if a provider submits a complete request for a provider-based determination for a facility that has not previously been found by CMS to have been inappropriately treated as provider-based under proposed revised § 413.65(j), the provider may bill and be paid for services at the facility as provider-based from the date of the application until the date that we determine that the facility or organization does not meet the provider-based rules under § 413.65. If CMS determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the complete request for a provider-based determination was submitted and the amount of payments that CMS estimates

should have been made in the absence of compliance with the provider-based requirements. We would consider a request ''complete'' only if it included all information we need to make an advance determination of provider-based status under § 413.65(b)(3).

Second, similar to what we specify in existing § 413.65(k), if we determine that a facility or organization that previously received a provider-based determination no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider reported to CMS as is required under § 413.65(c), treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.

Third, if we determine that a facility or organization that had previously received a provider-based determination no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS, as required under § 413.65(c), we are proposing to take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in proposed paragraphs (j)(3), (j)(4), and (j)(5). In short, we would treat such cases in the same way as if the provider had never obtained an advance determination. However, with respect to recovery of past payments for providers included in the grandfathering provision at proposed revised § 413.65(b)(2), we would not recover payments for any period before the provider's first cost reporting period beginning on or after July 1, 2003.

Also, we are proposing that the exception for good faith effort concerning recovery of overpayments under proposed revised §§ 413.65(j)(2) described above would apply to any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001.

k. Technical Amendments

We are proposing to correct a typographical error in the heading of paragraph (m) of § 413.65 so that it reads ''FQHCs and 'look alikes' ''.

In paragraph (n) of § 413.65, we are proposing to add a cross-reference to the requirements for provider-based status described in paragraph (b), for purposes of specifying the effective date of provider-based status.

L. CMS Authority Over Reopening of Intermediary Determinations and Intermediary Hearing Decisions on Provider Reimbursement

Our existing regulations provide various means for the reopening and revision of an intermediary determination or an intermediary hearing decision on provider reimbursement by the fiscal intermediary or the intermediary hearing officer(s) responsible for the determination or the hearing decision, respectively. (In this discussion, we will use the term ''intermediary'' to refer to, as applicable, the intermediary responsible for an intermediary determination (see §§ 405.1801(a) and 405.1803) or the intermediary hearing officer or panel of intermediary hearing officers responsible for an intermediary hearing decision (see §§ 405.1817 and 405.1831.)) Section 405.1885(a) provides that an intermediary ''may'' reopen an intermediary determination or an intermediary hearing decision, on its own initiative or at the request of a provider, within 3 years of the date of the notice of the intermediary determination or intermediary hearing decision. However, while § 405.1885(a) provides the intermediary with some discretion about whether to reopen an intermediary determination or an intermediary hearing decision, we have always considered the intermediary's discretion to be limited by any directives that may be issued by CMS. Thus, although § 405.1885(a) provides that the intermediary ''may'' reopen, that provision neither states nor implies that the Secretary lacks authority to direct the intermediary to reopen or not reopen a specific matter. Furthermore, CMS has prescribed, in Medicare Provider Reimbursement Manual, Part I (''PRM''), section 2931.2, criteria that guide the intermediary's reopening actions under ''405.1885(a) in the absence of a particular directive from CMS. Also, given that the intermediaries are CMS' contractors, we have always believed that, under basic principles of agency law, we have inherent authority to direct the actions of our own agents with respect to reopening matters under ''405.1885(a), just as for any other aspect of program administration. *See also* 42 U.S.C. 1395h and 1395kk(a); and 42 CFR 421.1(c), 421.5(b), 421.100(f), 421.124(a), and 421.126(b).

Under § 405.1885(b), an intermediary determination or an intermediary hearing decision ''shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Centers for Medicare & Medicaid Services notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Centers for Medicare & Medicaid Services.'' We have always considered the CMS notice, which is a precondition of mandatory intermediary reopening under § 405.1885(b), to be one in which we explicitly direct the intermediary to reopen. We have never considered a notice or other document from CMS that only states or implies that an intermediary determination or an intermediary hearing decision is inconsistent with law, regulations, CMS ruling, or CMS general instructions, sufficient to require intermediary reopening under § 405.1885(b). Moreover, our understanding has always been that the phrase ''law, regulations, or general instructions'' in § 405.1885(b) refers to the legal provisions in effect, as we understand such legal provisions, at the time the intermediary rendered the determination or hearing decision. Conversely, we have never considered changes in, or judicial explications of, ''law, regulations, or general instructions,'' that occur after the intermediary rendered the determination or hearing decision, sufficient to require intermediary reopening under § 405.1885(b). Also, § 405.1885(b) refers to the Secretary's agreement with an intermediary; we believe such agreement requires the intermediary to apply the law, regulations, CMS rulings, and CMS general instructions in effect, as we understand such legal provisions, when the intermediary determination or hearing decision was rendered. Accordingly, we have not instructed intermediaries to reopen and recover reimbursement, or to reopen and award additional reimbursement, due to a subsequent change in law or policy, whether the subsequent change is made in response to judicial precedent or otherwise.

Section 405.1885(c) provides: ''Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.'' We have always interpreted § 405.1885(c) to provide that authority to reopen an intermediary determination or an intermediary hearing decision is vested exclusively with the responsible intermediary, as distinct from the Provider Reimbursement Review Board (PRRB) and the Administrator of CMS (in the context of reviewing PRRB

decisions (see § 405.1875)) which may not reopen an intermediary determination or hearing decision and may not review an intermediary's denial of reopening. However, we have never considered the intermediary's authority to reopen an intermediary determination or hearing decision, which is exclusive under § 405.1885(c) only as to the PRRB and the Administrator of CMS (in the context of reviewing PRRB decisions), to limit CMS' authority to direct the actions of its own agents with respect to reopening matters. *See Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. 449, 452–53 (1999). (Section 405.1885(c) divests the PRRB of ''appellate jurisdiction to review the intermediary's refusal'' to reopen, but does not limit the Secretary's authority to direct an intermediary's ''original jurisdiction'' in the reopening area). As discussed previously, the regulations do not constrain CMS' authority to direct the intermediary to reopen or not reopen a specific matter; instead, CMS has placed generally applicable limits on the intermediary's discretion through the reopening criteria prescribed in section 2931.2 of the PRM. In addition, we have always believed that, under basic principles of agency law, the intermediary's discretion over a particular reopening matter is no less circumscribed by any directives that may be issued by CMS than would be the case for any other aspect of program administration.

Two recent court decisions conflict with our longstanding interpretation of the forgoing provisions of the reopening regulations. In *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001), the court found that a statement in a CMS ruling, changing CMS' interpretation of the statute in response to circuit court precedent, constituted a directive to the intermediary under § 405.1885(b) to reopen, notwithstanding an explicit directive in the CMS ruling that the change in interpretation was to be applied only prospectively. The court ordered the intermediary to reopen over the Secretary's objection. We disagree with the court's decision, which we believe does not comport with our settled interpretation (discussed above) of § 405.1885(b). Therefore, we are proposing to revise § 405.1885(b) to make clear that, in order to trigger the intermediary's obligation to reopen, the notice from CMS to the intermediary must explicitly direct the intermediary to reopen based on a finding that an intermediary determination or an intermediary hearing decision is inconsistent with the law, regulations, CMS ruling, or CMS general instructions in effect, and as we understood those legal provisions, at the time the determination or decision was rendered. We are also proposing to clarify § 405.1885 to reflect our longstanding interpretation (discussed above) that a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

The *Monmouth Medical Center* decision was followed in *Bartlett Memorial Medical Center* v. *Thompson*, 171 F. Supp. 2d 1215 (W.D. Okla. 2001). In a subsequent order in the *Bartlett Memorial Medical Center* case, the court concluded that a CMS ruling, which prohibited intermediary reopening on a particular reimbursement issue, improperly interfered with the intermediary's discretion under § 405.1885(c) over provider requests for reopening under § 405.1885(a). Accordingly, the court ordered the intermediary to act on the provider reopening requests without regard to the CMS ruling or any other involvement of the Secretary. We disagree with the court's decision, which we believe is contrary to our settled interpretation (discussed above) of § 405.1885(a) and (c). We believe the court's decision is also inconsistent with CMS' inherent authority to direct the activities of its own contractor-agents, the fiscal intermediaries, with respect to particular reopening matters, just as with any other aspect of program administration. Therefore, we are proposing, in a new paragraph (e) of § 405.1885 (the existing paragraph is proposed to be redesignated as paragraph (f)), to clarify that, notwithstanding an intermediary's discretion to reopen or not reopen under paragraphs (a) and (c) of § 405.1885, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section. To illustrate our proposal, revised § 405.1885(e) would clarify that CMS has full authority to direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision under § 405.1885(a) and (c) based on the reopening criteria of ''new and material evidence'' or ''clear and obvious error.'' *See* PRM § 2931.2.

VI. Proposed Changes to the Prospective Payment System for Capital-Related Costs

A. Background

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 43358), 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).

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

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

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year that are specified in § 412.312(c) of existing regulations. (Refer to the August 1, 2001 final rule (66 FR 39910) for 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 both during and after the transition period, and the policy for providing special exceptions.)

B. New Hospitals

Under the prospective payment system for capital-related costs, at § 412.300(b), a new hospital is defined as a hospital that is newly participating in the Medicare program (under current or previous ownership) for less than 2 years (see 56 FR 43418, August 30,

1991). During the 10-year transition period, under § 412.324(b), a new hospital was exempt from capital prospective payment system for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Effective with its third cost reporting period, a new hospital was paid under the appropriate transition methodology (either hold-harmless or fully prospective) for the remainder of the transition period. (If the hold-harmless methodology was applicable, hold-harmless payments would be made for 8 years, even if they extend beyond the 10-year transition period, which ended beginning with cost reporting periods beginning during FY 2002.)

This payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. These hospitals may not have sufficient occupancy in those initial 2 years and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient. For instance, hospitals newly participating in the Medicare program may not initially have adequate Medicare utilization. Because capital prospective payment system payments are made on a per discharge basis, a hospital only receives payments for its capital-related costs upon discharge of its Medicare patients. In addition, these hospitals did not have an opportunity to reserve previous years' capital prospective payment system payments to finance capital projects.

While the regulations provided for payments based on a percentage of costs for new hospitals for the first 2 years during the 10-year transition period, no provision was made for new hospitals once the 10-year transition was completed. However, we believe that the rationale for the policy applies equally to new hospitals even after the completion of the 10-year transition period. Accordingly, we are proposing, under § 412.304(c)(2), to provide special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. That is, we would pay new hospitals, as defined under § 412.300(b), 85 percent of their reasonable costs for their first 2 years of operation. Effective with their third year of operation, a new hospital would be paid based on the Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital prospective payment system). We believe this proposal would provide for more appropriate payments to new hospitals for their capital-related costs since initial capital expenditures may reasonably exceed the capital prospective payment system per discharge payment based on the Federal rate. The capital prospective payment Federal rate is based on industry-wide average capital costs rather than the experience of a new hospital. We believe this proposed policy would allow new hospitals to provide efficiency in the delivery of services and still make reasonable payments for their capital expenditures.

As was the case during the 10-year transition period, this proposed new hospital exemption would only be available to those hospitals that have not received reasonable cost-based payments under the Medicare program in the past, and would need special protection during their initial period of operation. This proposed exemption from the capital prospective payment system for the first 2 years of operation would not apply to a hospital that is ''new'' as an acute care hospital but that has operated in the past (under current or previous ownership) and has an historical Medicare asset base. Furthermore, a hospital that replaces its entire facility (regardless of a change of ownership) would not qualify for the new hospital exemption even though it may experience a significant change in its asset base. Thus, in accordance with § 412.300(b), a new hospital exemption would not apply in the following situations:

- A hospital that builds new or replacement facilities at the same or a new location, even if a change of ownership or a new leasing arrangement is involved;
- A hospital that closes and then reopens under the same or different ownership;
- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years; or
- A hospital that changes status from a prospective payment system-excluded hospital (paid under the TEFRA methodology) or another hospital prospective payment system (such as the inpatient rehabilitation facility prospective payment system) to a hospital that is subject to the capital prospective payment system for acute care hospitals.

C. Extraordinary Circumstances

When we implemented the capital prospective payment system in FY 1992, a number of commenters requested that we provide for a separate exceptions payment to account for extraordinary circumstances beyond a hospital's control that would require the hospital to make unanticipated major capital expenditures (56 FR 43411, August 30, 1991). In response to the commenters' request, we provided in the regulations at § 412.348(f) that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, a fire, or an earthquake. For more detailed information regarding this policy, refer to the August 30, 1991 **Federal Register** (56 FR 43411).

To clarify that this policy regarding additional payments for extraordinary circumstances also applies to periods beginning on or after October 1, 2001, we are proposing to revise § 412.312 by adding a new paragraph (e) to specify that payment is made for extraordinary circumstances as provided for in § 412.348(f) for cost reporting periods after the transition period, that is, on or after October 1, 2001.

D. Restoration of the 2.1 Percent Reduction to the Standard Federal Capital Prospective Payment System Payment Rate

Section 1886(g)(1)(A) of the Act, as amended by section 4402 of Public Law 105–33, requires the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate (and the unadjusted hospital-specific rate) by 2.1 percent for discharges on or after October 1, 1997, and through September 30, 2002, in addition to applying the budget neutrality factor used to determine the Federal capital prospective payment system payment rate in effect on September 30, 1995. The budget neutrality factor effective for September 30, 1995, was 0.8432 (59 FR 45416). Therefore, application of the budget neutrality factor (as specified under section 1886(g)(1)(A) of the Act) was equivalent to a 15.68 percent reduction to the unadjusted standard Federal capital prospective payment system payment rate and the unadjusted hospital-specific rate in effect on September 30, 1997. The additional 2.1 reduction to the rates in effect on September 30, 1997 resulted in a total reduction of 17.78 percent. Accordingly, under the statute, the additional 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002 (§ 412.308(b)(5)). Therefore, we are proposing to revise § 412.308(b) to add a new paragraph (b)(6) to restore the 2.1 percent reduction to the unadjusted

standard Federal capital prospective payment system payment rate (as provided under § 412.308(c)) for discharges occurring on or after October 1, 2002, to the level that it would have been without the reduction. (Since FY 2001 was the final year of the 10-year transition period, we no longer update the hospital-specific rate and, therefore, we also no longer restore the 2.1 percent reduction to that rate as provided under § 412.328(e)(1).)

As described in the August 29, 1997 final rule (62 FR 46012), we determined the reduction factor for FY 1998 by deducting both the FY 1995 budget neutrality factor (0.1568) and the 2.1 percent reduction (0.021) from 1 (1 − 0.1568 − 0.021 = 0.8222). We then applied the 0.8222 to the unadjusted standard Federal rate. Therefore, to determine the adjustment factor needed to restore the 2.1 percent reduction, we would divide the amount of the adjustment without the 2.1 percent reduction (1 − 0.1568 = 0.8432) by the amount of the adjustment with the 2.1 percent reduction (0.8222). Accordingly, we are proposing to restore the 2.1 percent reduction for discharges occurring on or after October 1, 2002, under proposed § 413.308(b)(6), by applying a factor of 1.02554 (0.8432/0.8222) to the unadjusted standard Federal capital prospective payment system payment rate under § 412.308(c), that was in effect on September 30, 2002.

E. Clarification of Special Exceptions Policy

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 described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). In accordance with § 412.348(g)(7), hospitals are eligible to receive special exceptions payments for the 10 years after the cost reporting year in which they complete their project, which can be no later than the hospital's cost reporting period beginning before October 1, 2001.

During the 10-year capital prospective payment system transition period, regular exceptions under §§ 412.348(b) through (e) paid the same as or more (between 70 percent and 90 percent of costs, depending on the type of hospital) than the special exceptions provision under § 412.348(g) (70 percent for all eligible hospitals). Therefore, it was not until cost reporting periods beginning on or after October 1, 2001 (the end of the transition period) that eligible hospitals could actually begin receiving additional payments under the special exceptions provision. As we stated in the July 30, 1999 final rule (64 FR 41528), we believe that, since any substantive changes to this policy could have a significant impact, the appropriate forum for addressing the special exceptions policy is through the legislative process in Congress rather than the regulations process. Since hospitals are beginning to receive additional payments under this provision, we have received several questions regarding current policy at § 412.348(g). Therefore, while we are not proposing any changes to the special exceptions policy, we are providing the following clarifications to the existing regulations.

Under § 412.348(g)(1), to be eligible for special exception payments, a hospital must be either a sole community hospital (SCH), an urban hospital with at least 100 beds that has a disproportionate share (DSH) percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), or a hospital with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Because a hospital's SCH status, DSH patient percentage, and combined utilization may fluctuate from one cost reporting year to the next, the special exceptions eligibility criteria are applied for each cost reporting period throughout the 10-year special exceptions period. A hospital receives special exceptions payments only for those years in the 10-year period in which it meets the eligibility requirements in § 412.348(g)(1). Therefore, a hospital might be eligible for a special exception payment in one year, not be eligible the next year, and then subsequently qualify during the 10-year special exceptions period.

The project need criteria in § 412.348(g)(2) also state that a hospital must obtain any required approval from a State or local planning authority. However, in States where a certificate of need or approval is not required by the State or local planning authority, the hospital must provide the fiscal intermediary with appropriate documentation (such as project plans from the hospital's board of directors) that demonstrates that the requirements of § 412.348(g)(3) concerning the age of assets test and § 412.348(g)(4) concerning the excess capacity test for urban hospitals are met. We understand that a State planning authority and a hospital may define a project differently. Accordingly, we would allow the hospital to use either the definition provided by the project within the certificate of need (in States where a certificate of need is required), or other appropriate documentation provided from the hospital's project plans (such as project plans as specified in the minutes of the meetings of the hospital's board of directors).

In determining a hospital's special exceptions payment amount, as described in § 412.348(g)(8), for each cost reporting period, the cumulative payments made to the hospital under the capital prospective payment system are compared to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the capital prospective payment system. This comparison is offset by 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). The minimum payment level is 70 percent for all hospitals, regardless of class, as set forth in § 412.348(g)(6), for the duration of the special exceptions provision.

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, § 412.348(g)(9) requires that hospitals eligible for special exception payments 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). In order for an eligible hospital to receive special exception payments, this documentation had 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.

VII. Proposed Changes for Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

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

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Public Law 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts apply to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts. In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), these excluded hospitals and hospital units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling. The ceiling would be computed using the hospital's or unit's target amount from the previous cost reporting period updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations.

2. Updated Caps for New Excluded Hospitals and Units

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. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529). Under the statutory methodology, a ''new'' hospital or unit is a hospital or unit that falls within one of the three classes of hospitals or units (psychiatric, rehabilitation or long-term care) that first receives payment as a hospital or unit excluded from the acute care hospital inpatient prospective payment system on or after October 1, 1997. The amount of payment for a ''new'' hospital or unit would be determined as follows:

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

The proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts proposed for each class of new excluded hospitals and hospital units for cost reporting periods beginning during FY 2003. These figures are updated to reflect the proposed projected market basket increase percentage of 3.4 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by the CMS Office of the Actuary based on its historical experience with the hospital inpatient prospective payment system). 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 2003 proposed labor-related share	FY 2003 proposed nonlabor-related share
Psychiatric	$7,047	$2,801
Long-Term Care	17,269	6,866

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals and units since they will be paid under the inpatient rehabilitation facility prospective payment system.

3. Establishment of a Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

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

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

4. Implementation of a Prospective Payment System for Long-Term Care Hospitals

In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we are proposing (as published in the March 22, 2002 proposed rule (67 FR 13415)) the establishment of a per discharge, DRG-based prospective payment system for long-term care hospitals as described in

section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002. As part of the implementation process, we are proposing a 5-year transition period from reasonable cost-based reimbursement to the long-term care hospital prospective payment system Federal rate. We are also proposing that a long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate. Under the March 22, 2002 proposed rule, a blend of the reasonable cost-based reimbursement percentage and the prospective payment Federal rate percentage would be used to determine a long-term care hospital's total payment under the prospective payment system during the transition period. We would expect long-term care hospitals to be paid under the full Federal prospective rate for cost reporting periods beginning on or after October 1, 2006.

B. Criteria for Exclusion of Satellite Facilities from the Hospital Inpatient Prospective Payment System

Existing regulations at 42 CFR 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in the same building as another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.22(h), relating to satellites of hospitals excluded from the acute care hospital inpatient prospective payment system, defines a satellite facility as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.25(e), relating to satellites of excluded hospital units, defines a satellite facility as a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Because of the similarities between the definitions of the two types of satellite facilities and the definition of a hospital-within-a-hospital, questions have been raised as to whether satellite facilities must meet the ''hospital-within-a-hospital'' criteria in § 412.22(e) regarding having a governing body, chief medical officer, medical staff, and chief executive officer that are separate from those of the hospital with which space is shared.

Although the separateness of satellite facilities of excluded hospitals and satellite facilities of excluded units of hospitals is not explicitly required under existing regulations, we believe these two types of satellite facilities are similar enough to hospitals-within-hospitals to warrant application of more closely related criteria to all of them. Specifically, satellite facilities are like hospitals-within-hospitals in that the satellites are physically located in acute care hospitals that are paid for their inpatient services under the acute care hospital inpatient prospective payment system. Moreover, both satellite facilities and hospitals-within-hospitals provide inpatient hospital care that is paid for at higher rates than would apply if the facility were treated by Medicare as a part of the acute care hospital.

In view of these facts, it is important that we establish clear criteria for ensuring that these facilities are not merely units of the hospitals in which they are located, but are, in fact, organizationally and functionally separate from those hospitals. Therefore, we are proposing to revise § 412.22(h)(2) to specify that, effective for cost reporting periods beginning on or after October 1, 2002, a hospital having a satellite facility would qualify for exclusion from the acute care hospital inpatient prospective payment system only if that satellite facility is not under the authority or control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located. We also are proposing to revise § 412.25(e)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2002, a hospital unit having a satellite facility would qualify for exclusion from the acute care hospital inpatient prospective payment system only if it is not under the authority or control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.

C. Critical Access Hospitals (CAHs)

1. Background

Section 1820 provides for a nationwide Medicare Rural Hospital Flexibility Program (MRHF). (MRHF replaced the 7-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program.) Under section 1820 of the Act, as amended, certain rural providers may be designated as critical access hospitals (CAHs) under the MRHF program if they meet qualifying criteria and the conditions for designation specified in the statute. Implementing regulations for section 1820 of the Act are located at 42 CFR Part 485, Subpart F.

2. Election of Optional Payment Method

Under existing regulations at 42 CFR 413.70(b), CAHs may elect to be paid for services to their outpatients under an optional method. Facilities making this election are paid an amount for each outpatient visit that is the sum of the reasonable costs of facility services, as determined under applicable regulations, and, for professional services otherwise payable to the physician or other practitioner, 115 percent of the amounts that otherwise would be paid for the services if the CAH had not elected payment under the optional method. To enable intermediaries to make these payments accurately and to avoid possible delays in or duplications of payment, we specify in § 413.70(b)(3) that each CAH electing payment under the optional method must inform the intermediary in writing of that election annually, at least 60 days before the start of the affected cost reporting period (65 FR 47100, August 1, 2000, and 66 FR 31272, June 13, 2001).

Since the publication of this regulation, some CAHs have expressed concern that requiring a 60-day advance notice of the election of the optional payment method limits their flexibility, and have suggested that a shorter advance notice period would be appropriate. We have contacted our fiscal intermediaries to obtain feedback on the feasibility of changing the period of advance notification, since the fiscal intermediaries would need to make appropriate bill processing changes to allow any shorter time for notification of election of the optional method. Some fiscal intermediaries stated that requiring less than 60 days' advance notice is impractical, while others believed that needed changes could be made with as little as 2 weeks' advance notice. Given the diversity of feedback on this issue and our desire to allow CAHs as much flexibility as possible, we are proposing to revise § 412.30(b)(3) to allow the required advance notice period to be determined by each individual fiscal intermediary for the CAHs it services, as long as the required advance notice is not less than 14 days or more than 60 days before the start of each affected cost reporting period.

3. Use of the Resident Assessment Instrument (RAI) by CAHs

Among the existing regulations implementing section 1820 of the Act are specific conditions that a hospital must meet to be designated as a CAH. To help protect the health and safety of Medicare patients who are being furnished post-hospital skilled nursing facility (SNF) level of care in a CAH, our regulations require CAHs to comply with some, but not all, of the Medicare SNF conditions of participation at 42 CFR part 483, subpart B. Specifically, the regulations at § 485.645(d) provide that in order for a CAH to use its beds to provide post-hospital SNF care, the CAH must be in substantial compliance with nine of the SNF requirements contained in part 483, subpart B. Included among the nine requirements are requirements for comprehensive assessments, comprehensive care plans, and discharge planning as specified in § 483.20(b), (k), and (l). (We note that the existing § 485.645(d)(6) incorrectly cites these regulation cross-references as ''§ 483.20(b), (d), and (e).'' When we revised § 483.20 on December 23, 1997 (63 FR 53307), we inadvertently did not make conforming cross-reference changes in § 485.645(d)(6). In this proposed rule, we are proposing to make these conforming cross-reference changes.) Section 483.20(b) provides that a facility must make a comprehensive assessment of a resident's needs using the resident assessment instrument (RAI), specified by the State, on all its swing-bed patients.

We have received inquiries regarding the need for CAHs to use the RAI for patient assessment and care planning. The inquirers consider the RAI a lengthy and burdensome instrument and pointed out that CMS currently does not require CAHs to report data from the RAI for quality or payment purposes.

We required former RPCHs to use the RAI for the assessment of swing-bed patients to avoid the possibility of negative outcomes that might extend the length of stays in these hospitals, which provided limited services. In addition, we believed that the use of the RAI would help to ensure that patient needs are met when patients are in the facility for an extended period of time. Swing-bed hospitals were not required to use any patient assessment instrument because we believed that the hospital conditions of participation included requirements that were appropriate safeguards to protect the health and safety of Medicare patients. Currently, the regulations at § 483.20(f) require all long-term care facilities to collect and submit assessment data from the RAI to the State for quality and payment purposes. There are no such collection and submission requirements for CAHs.

We have gathered information from the provider community, State surveyors, and staff involved in the development of quality indicators and prospective payment system rates for SNFs to determine the feasibility of continuing to require CAHs to comply with the requirement for use of the RAI for patient assessments. Based on the information received, we have determined that there are no specific patient benefits involved in requiring CAHs to use the RAI for patient assessment purposes.

In the interest of reducing burden, where possible, and based on our analysis of the current significance of the requirement for use of the RAI for patient assessments in CAHs, we believe it is appropriate to propose the elimination of the requirement for CAHs to complete an RAI without jeopardizing patient health and safety. A CAH would still be required to capture assessment data for its SNF patients but would have the flexibility to document the assessment data in the medical record in a manner appropriate for its facility. We believe there are sufficient safeguards in the CAH regulations to ensure the health and safety of each SNF patient in a CAH. The facility would still be required to develop a comprehensive care plan for each SNF patient that includes measurable objectives and a timetable to meet a patient's medical, nursing, and psychosocial needs that are identified in an assessment. Also, a post-discharge plan of care would address post-hospital care needs of the patient. All of this information (assessment, plan of care, and discharge plans) must be maintained in the patient's medical record.

We are proposing to revise § 485.645 to specify that CAHs are required to complete a comprehensive assessment, comprehensive care plan, and discharge planning in accordance with the requirements of § 483.20(b), (k), and (l), except that the CAH is not required to use the RAI specified by the State, and is not required to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b).

VIII. MedPAC Recommendations

We have reviewed the March 1, 2002 report submitted by MedPAC to Congress and have given it careful consideration in conjunction with the proposals set forth in this document. MedPAC's recommendations for payments for Medicare inpatient hospital services in its March 2002 report focused mainly on accounting for changes in input prices for the hospital market basket (Recommendation 2A) and on increases in the base rate for inpatient hospital services by applying the annual update factors (Recommendations 2B–1 and 2B–2).

In Recommendation 2A, MedPAC recommended that the Secretary should use wage and benefit proxies that most closely match the training and skill requirements of health care occupations in all input price indexes used for updating payments. MedPAC further indicated that, in determining index weights, measures specific to the health sector and to occupation categories in which health care plays a major role should be emphasized. Our proposal to rebase and revise the hospital market basket, including cost category weights and price proxies, that is used in determining the update factors for payments for inpatient hospital services is presented in section IV. of this proposed rule.

Recommendations 2B–1 and 2B–2 concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the acute care hospital inpatient prospective payment system are discussed in Appendix C to this proposed rule.

IX. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.hcfa.gov/stats/pufiles.htm.* Data files, and the cost for each, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. Expanded Modified MedPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records

for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. (The file is a Federal fiscal year file, that is, discharges occurring October 1 through September 30 of the requested year.) The records are stripped of most data elements that would permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11,420,000 records. Under the requirements of these notices, an agreement for use of CMS Beneficiary Encrypted Files must be signed by the purchaser before release of these data. For all files requiring a signed agreement, please write or call to obtain a blank agreement form before placing an order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 2001 MedPAR file used for the FY 2003 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge.
File Cost: $3,655.00 per fiscal year.
Periods Available: FY 1988 through FY 2001.

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the December 24, 1984 **Federal Register** notice, and amended by the July 2, 1985 notice. This file is a subset of the Expanded Modified MedPAR-Hospital (National) as described above. Under the requirements of these notices, an agreement for use of CMS Beneficiary Encrypted Files must be signed by the purchaser before release of these data. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 2001 MedPAR file used for the FY 2003 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge.
File Cost: $1,130.00 per State per year.
Periods Available: FY 1988 through FY 2001.

3. CMS Wage Data

This file contains the hospital hours and salaries for FY 1999 used to create the proposed FY 2003 prospective payment system wage index. The file will be available by the beginning of January for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.
File Cost: $165.00 per year.
Periods Available: FY 2003 PPS Update.

4. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet.
File Cost: $165.00 per year.
Periods Available: FY 2003 PPS Update.

5. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Area (MSA).

Media: Diskette/Internet.
File Cost: $165.00 per year.
Periods Available: FY 2003 PPS Update.

6. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00 per year.
Periods Available: FY 2003 PPS Update.

7. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge.
File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(Note: The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, and PPS–XVII Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, and PPS–XVII Hospital Data Set Files (refer to item 9 below).)

8. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or

reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.
File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(Note: The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, and PPS–XVII Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, and PPS–XVII Hospital Data Set Files (refer to item 9 below).)

9. PPS–XIII to PPS–XVII Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set are updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet.
File Cost: $2,500.00.

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98
PPS–XVI	10/01/98	10/01/99
PPS–XVII	10/01/99	10/01/00

10. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet.
File Cost: $265.00.
Periods Available: FY 2003 PPS Update.

11. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet.
Price: $165.00 per year/per file.
Periods Available: FY 1985 through FY 2001.

12. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- NPRM.
- Final rule.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2003 PPS Update.

13. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2003 PPS Update.

14. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.) Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2003 PPS Update.

15. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet.
File cost: No charge.
Periods Available: FY 2003 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4548.

B. 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.

However, the majority of the collection requirements contained in this proposed rule are currently approved.

Section IX.B.1. below lists the OMB approval numbers and the current

expiration dates for the collection requirements, referenced by 42 CFR Part, in this proposed rule that are currently approved. In addition, as summarized below, section IX.B.2. of this proposed rule outlines the proposed collection requirements referenced in this proposed rule for which we are seeking public comment, as required under the PRA of 1995.

1. Currently Approved Requirements

Regulation references in 42 CFR	OMB approval No.	Current expiration date
Part 412	0938–0691	September 30, 2002.
	0938–0050	May 31, 2004.
	0938–0573	September 30, 2002.
Part 413	0938–0050	May 31, 2004.
	0938–0667	October 31, 2002.
	0938–0477	June 30, 2002.
Part 489	0938–0667	October 31, 2002.

2. Proposed Requirements for Public Comment

Section 412.230 Criteria for an Individual Hospital Seeking Redesignation to Another Rural Area or an Urban Area.

Appropriate Wage Data

As specified in this section, a new hospital must accumulate and provide at least 1 year of wage data to CMS for the purposes of applying for reclassification. While this collection requirement is subject to the PRA, we believe the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

Section 413.65 Requirements for a Determination That a Facility or an Organization Had Provider-Based Status

Responsibility for Obtaining Provider-Based Determinations

As summarized in this section, a potential main provider seeking an advance determination of provider-based status for a facility that is located on the main campus of the potential main provider would be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. In addition, the provider seeking such an advance determination would be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS upon request.

We believe the burden associated with these requirements is estimated to average 1.5 hours per provider, for approximately 3,000 providers per year, for an annual burden of 4,500 annual burden hours. This estimate is based on fact the providers currently maintain the necessary data and that minimal effort would be required to locate and review the appropriate data.

Clinical Services

The clinical services of the facility or organization seeking provider-based status and the main provider would be required to maintain an unified retrieval system (or cross reference) of the main provider for all patient medical records for those patients treated in the facility or organization.

While this collection requirement is subject to the PRA, we believe the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b) (2) and (b)(3).

Section 482.12 Conditions of Participation: Governing Body

Standard: Emergency Services

If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital would be required to assure that the medical staff have written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

While this collection requirement is subject to the PRA, we believe the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

Section 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases

Application to Inpatients—Admitted Emergency Patients

If a hospital admits an individual with an unstable emergency medical condition for stabilizing treatment, as an inpatient, and stabilizes that individual's emergency medical condition, the period of stability would be required to be documented by relevant clinical data in the individual's medical record, before the hospital has satisfied its special responsibilities under this section with respect to that individual.

While this collection requirement is subject to the PRA, we believe the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: John Burke, Attn: CMS–1203–P, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, CMS Desk Officer Attn: CMS–1203–P.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the ''DATES'' section of this preamble and respond to those comments in the preamble to that rule. We emphasize that section 1886(e)(5) of the Act requires the final rule for FY 2003 to be published by August 1, 2002, and we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

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 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 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, 42 CFR chapter IV is proposed to be amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as follows:

1. The authority citation for Part 405, Subpart R continues to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

2. Section 405.1885 is amended by revising paragraph (b), redesignating paragraph (e) as paragraph (f), and adding a new paragraph (e), to read as follows:

§ 405.1885 Reopening a determination or decision.

* * * * *

(b)(1) An intermediary determination or an intermediary hearing decision shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, CMS—

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

* * * * *

(e) Nothwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 412.4 [Amended]

2. In § 412.4 (f)(1), the reference ''paragraph (b) or (c)'' is removed and ''paragraph (b)(1) or (c)'' is added in its place.

3. Section 412.22 is amended by—

a. Revising the introductory text of paragraph (h)(2).

b. Republishing the introductory text of paragraph (h)(2)(iii).

c. Redesignating paragraphs (h)(2)(iii)(A) through (F) as paragraphs (h)(2)(iii)(B) through (G), respectively. d. Adding new paragraph (h)(2)(iii)(A).

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the authority or control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.

* * * * *

4. Section 412.25 is amended by—

a. Revising the introductory text of paragraph (e)(2).

b. Republishing the introductory text of paragraph (e)(2)(iii).

c. Redesignating paragraphs (e)(2)(iii)(A) through (F) as paragraphs (e)(2)(iii)(B) through (G), respectively.

d. Adding new paragraph (e)(2)(iii)(A).

§ 412.25 Excluded hospitals units: Common requirements.

* * * * *

(e) *Satellite facilities.* * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the authority or control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.

* * * * *

§ 412.63 [Amended]

5. Section 412.63 is amended by—

a. In paragraph (x)(2)(i)(A), removing the phrase ''tabulating the hospital's data'' and adding in its place ''tabulating its data''.

b. Removing paragraphs (x)(3) and (x)(4).

c. Redesignating paragraph (x)(5) as paragraph (x)(3).

6. Section 412.80 is amended by revising paragraph (a)(2) to read as follows:

§ 412.80 Outlier cases: General provisions.

(a) *Basic rule.* * * *

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a

hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in § 412.84(h), exceed the DRG payment for the case, payments for indirect costs of graduate medical education (§ 412.105), and payments for serving disproportionate share of low-income patients (§ 412.106), plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

* * * * *

7. Section 412.92 is amended by revising paragraph (c)(2), to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(c) *Terminology.* * * *

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, if a hospital seeking sole community hospital designation can demonstrate that no more than 3 percent of the services it provides overlap with the services provided by a nearby hospital that would otherwise be considered a like hospital under this definition, CMS will not consider the nearby hospital to be a like hospital.

* * * * *

8. Section 412.105 is amended by—

A. Republishing the introductory text of paragraph (a).

B. Revising paragraph (a)(1).

C. Revising paragraph (b).

D. Revising paragraph (f)(1)(vi).

E. Making the following cross-reference changes in paragraph (f)(1):

i. In paragraph (f)(1)(vii), the reference ''§ 413.86(g)(12)'' is removed and ''§ 413.86(g)(13)'' is added in its place.

ii. In paragraph (f)(1)(viii), the reference ''§ 413.86(g)(7)'' is removed and ''§ 413.86(g)(8)'' is added in its place.

iii. In paragraph (f)(1)(ix), the reference ''§§ 413.86(g)(8)(i) and (g)(8)(ii) of this subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(ii) of this subchapter'' is added in its place; the reference ''§§ 413.86(g)(8)(i) and (g)(8)(iii)(B) of this subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(iii)(B) of this subchapter'' is added in its place; and the reference ''§§ 413.86(g)(8)(i) and (g)(8)(iii)(A) of this subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(iii)(A) of this subchapter'' is added it its place.

iv. In paragraph (f)(1)(x), the reference ''§ 413.86(g)(12)'' is removed and ''§ 413.86(g)(13)'' is added in its place; and the reference ''§ 413.86(g)(11)'' is removed and ''§ 413.86(g)(12)'' is added in its place.

v. In paragraph (f)(1)(xi), the reference ''§ 413.86(g)(9)'' is removed and ''§ 413.86(g)(10)'' is added in its place.

vi. In paragraph (f)(1)(xii), the reference ''§ 413.86(g)(10)'' is removed and ''§ 413.86(g)(11)'' is added in its place.

The revisions read as follows:

§ 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).

(i) 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 cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, 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.

(ii) 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.

(iii) The exception for closed hospitals and closed programs described in paragraph (f)(1)(ix) of this section applies only in the first cost reporting period in which the receiving hospital trains the displaced full-time equivalent residents.

(iv) In the cost reporting period following the last year the receiving hospital's full-time equivalent cap is adjusted for the displaced resident(s), the resident-to-bed ratio cap in paragraph (a)(1) of this section is calculated as if the displaced full-time equivalent residents had not trained at the receiving hospital in the prior year.

* * * * *

(b) *Determination of number of beds.* (1) For purposes of this section, subject to the provisions of paragraph (b)(2) of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

(2) Effective for discharges occurring on or after October 1, 2002, a hospital's number of beds is equal to the lower of the number of beds as determined under paragraph (b)(1) of this section, or the average daily census (as determined in accordance with § 412.322(a)(2) of this chapter) divided by 35 percent.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.*

(1) * * *

(vi) Hospitals that are part of the same affiliated group (as defined in § 413.86(b) of this subchapter) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis, as specified in § 413.86(g)(7) of this chapter.

* * * * *

9. 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.* (1) The fiscal intermediary determines whether a hospital meets the criteria specified in paragraph (a) of this section.

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The fiscal 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.

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(5) The fiscal intermediary will evaluate on an ongoing basis, whether or not a hospital continues to qualify for MDH status. This evaluation includes an ongoing review to ensure that the hospital continues to meet all of the

criteria specified in paragraph (a) of this section.

(6) If the fiscal intermediary determines that a hospital no longer qualifies for MDH status, the change in status will become effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

(7) A hospital may reapply for MDH status following its disqualification only after it has completed another cost reporting period that has been audited and settled. The hospital must reapply for MDH status in writing to its fiscal intermediary and submit the required documentation.

(8) If a hospital disagrees with an intermediary's determination regarding the hospital's initial or ongoing MDH status, the hospital may notify its fiscal intermediary and submit other documentable evidence to support its claim that it meets the MDH qualifying criteria.

(9) The fiscal intermediary's initial and ongoing determination is subject to review under subpart R of Part 405 of this chapter. The time required by the fiscal intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

* * * * *

10. Section 412.113 is amended by revising paragraphs (c)(2)(ii) and (c)(2)(iii) to read as follows:

§ 412.113 Other payments.

* * * * *

(c) *Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements.* * * *

(2) * * *

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.

(iii) A hospital or CAH that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

* * * * *

11. Section 412.230 is amended by adding a new paragraph (e)(2)(iii) to read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(e) *Use of urban or other rural area's wage index.* * * *

(2) *Appropriate wage data.* * * *

(iii) For purposes of this paragraph (e)(2), if a new owner does not accept assignment of the existing hospital's provider agreement in accordance with § 489.18 of this chapter, the hospital will be treated as a new provider with a new provider number. In this case, the wage data associated with the previous owner of the hospital cannot be used in calculating the new hospital's 3-year average hourly wage. Once a new hospital has accumulated at least 1 year of wage data, it is eligible to apply for reclassification on the basis of those data.

* * * * *

12. Section 412.273 is amended by—

A. Revising the section heading.

B. Revising paragraph (b)(2).

C. Redesignating paragraph (d) as paragraph (e).

D. Add a new paragraph (d).

§ 412.273 Withdrawing an application, terminating an approved 3-year reclassification, or canceling a previous withdrawal or termination.

* * * * *

(b) *Request for termination of approved 3-year wage index reclassifications.* * * *

(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 cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(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. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination.

(iii) In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1.

* * * * *

(d) *Process for canceling a previous withdrawal or termination.* A hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2).

* * * * *

13. Section 412.304 is amended by revising paragraph (c) to read as follows:

§ 412.304 Implementation of the capital prospective payment system.

* * * * *

(c) *Cost reporting periods beginning on or after October 1, 2001.*

(1) *General.* Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under § 412.308(a) and (b) and updated under § 412.308(c).

(2) *Payment to new hospitals.* For cost reporting periods beginning on or after October 1, 2002—

(i) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient.

(ii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under § 412.312.

* * * * *

14. Section 412.308 is amending by adding a new paragraph (b)(6) to read as follows:

§ 412.308 Determining and updating the Federal rate.

* * * * *

(b) *Standard Federal rate.* * * *

(6) For discharges occurring on or after October 1, 2002, the 2.1 percent reduction provided for under paragraph (b)(5) of this section is eliminated from the unadjusted standard Federal rate in effect on September 30, 2002, used to

determine the Federal rate each year under paragraph (c) of this section.

* * * * *

15. Section 412.312 is amended by adding a new paragraph (e) to read as follows:

§ 412.312 Payment based on the Federal rate.

* * * * *

(e) *Payment for extraordinary circumstances.* Payment for extraordinary circumstances is made as provided for in § 412.348(f) for cost reporting periods beginning on or after October 1, 2001.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as follows:

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 413.65 is amended by—

A. Revising paragraph (a)(1)(ii)(G) and adding a new paragraph (a)(1)(ii)(J).

B. Revising the definition of ''Department of a provider'', ''Provider-based entity'', and ''Remote location of a hospital'' under paragraph (a)(2).

C. Revising paragraphs (b)(2), (b)(3), and (d).

D. Removing paragraph (j).

E. Redesignating paragraphs (h) and (i) as paragraphs (i) and (j), respectively.

F. Redesignating paragraph (f) as paragraph (h).

G. Redesignating paragraph (e) as paragraph (f).

H. Adding a new paragraph (e).

I. Revising redesignated paragraph (f).

J. Revising the introductory text of paragraph (g), and paragraphs (g)(1), (g)(2), and (g)(7).

K. Revising redesignated paragraphs (h), (i), and (j).

L. Revising paragraph (k).

M. Revising the heading of paragraph (m).

N. Revising paragraph (n).

§ 413.65 Requirements for a determination that a facility or an organization had provider-based status.

(a) *Scope and definitions.* (1) *Scope.*

* * *

(ii) This section does not apply to the following facilities:

* * * * *

(G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services (as defined in section 1861(jj) of the Act), facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services.

* * * * *

(J) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments).

(2) *Definitions.* * * *

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term ''department of a provider'' does not include an RHC or, except as specified in paragraph (m) of this section, an FQHC.

* * * * *

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

* * * * *

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term ''remote location of a hospital'' does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

(b) *Responsibility for obtaining provider-based determinations.* * * *

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), (g), (h), and (i), of this section will not apply to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. For purposes of this paragraph (b)(2), a facility is considered as provider-based on October 1, 2000 if, on that date, it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3)(i) Except as specified in paragraphs (b)(2) and (b)(5) of this section, if a potential main provider seeks an advance determination of provider-based status for a facility that is located on the main campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and

hospital-based entities described in paragraph (g) of this section. The provider seeking such an advance determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS upon request.

(ii) If the facility is not located on the main campus of the potential main provider, the provider seeking an advance determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated as a joint venture or under a management contract, the requirements of paragraph (f) or paragraph (h) of this section, as applicable. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

* * * * *

(d) *Requirements applicable to all facilities or organizations.* Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements to be determined by CMS to have provider-based status:

(1) *Licensure.* The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

(2) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(3) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

(4) *Public awareness.* The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(5) *Obligations of hospital outpatient departments and hospital-based entities.* In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section.

(e) *Additional requirements applicable to off-campus facilities or organizations.* Except as described in paragraphs (b)(2) and (b)(5) of this section, any facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must meet both the requirements in paragraph (d) of this section and all of the following additional requirements, in order to be determined by CMS to have provider-based status.

(1) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

(2) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by

compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(3) *Location.* The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider, except when the requirements in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this section are met:

(i) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(e)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(ii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(ii)(A) or paragraph (e)(3)(ii)(B) of this section because it was not in operation during all of the 12-month period described in paragraph (e)(3)(ii) of this section, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(ii) of this section, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criteria in paragraphs (e)(3)(i) through (e)(3)(iii) of this section.

(f) *Provider-based status for joint ventures.* A facility or organization that is not located on the campus of the potential main provider cannot be considered provider-based if the facility or organization is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the hospital or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* To qualify for provider-based status in relation to a hospital, a facility or organization must comply with the following requirements:

(1) The following departments must comply with the antidumping rules of § 489.20(l), (m), (q), and (r) and § 489.24 of this chapter:

(i) Any facility or organization that is located on the main hospital campus and is treated by Medicare under this section as a department of the hospital; and

(ii) Any facility or organization that is located off the main hospital campus that is treated by Medicare under this section as a department of the hospital and is a dedicated emergency department, as defined in § 489.24(b) of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of part 414 of this chapter.

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department of hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules in § 489.24 of this chapter, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(i) The notice must be one that the beneficiary can read and understand.

(ii) If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(iii) The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital.

(iv) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(v) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of § 489.24 of this chapter, notice, as described in this paragraph (g)(7), must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

* * * * *

(h) *Management contracts.* A facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of paragraphs (d) and (e) of this section, but is operated under management contracts, must also meet all of the following criteria:

(1) The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at Part 414 of this chapter. ''Leased'' employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) are not considered to be employees of the provider for purposes of this paragraph.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (e)(2)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (e)(2)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(i) *Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.

(j) *Inappropriate treatment of a facility or organization as provider-based.* (1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request an advance determination of provider-based status from CMS under paragraph (b)(3) of this section and CMS determines that the facility or organization did not meet the requirements for provider-based status under paragraphs (d) through (i) of this section, as applicable (or, in any period before the effective date of these regulations, the provider-based requirements in effect under Medicare program regulations or instructions), CMS will—

(i) Issue notice to the provider in accordance with paragraph (j)(3) of this section, adjust the amount of future payments to the provider for services of the facility or organization in accordance with paragraph (j)(4) of this section, and continue payments to the provider for services of the facility or organization only in accordance with paragraph (j)(5) of this section; and

(ii) Except as otherwise provided in paragraphs (b)(2), (b)(5), or (j)(2) of this section, recover the difference between the amount of payments that actually was made and the amount of payments that CMS estimates should have been made, in the absence of compliance with the provider-based requirements, to that provider for services at the facility or organization for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889 of this chapter.

(2) *Exception for good faith effort.* CMS will not recover any payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001, if, during all of that period—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(4) of this section were met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(3) *Notice to provider.* CMS will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (j)(1)(ii) of this section, and that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(4) of this section.

(4) *Adjustment of payments.* CMS will adjust future payments to the provider or the facility or organization, or both, to approximate as closely as possible the amounts that would be paid for the same services furnished by a freestanding facility.

(5) *Continuation of payment.* (i) The notice of denial of provider-based status sent to the provider will ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, of whether the provider intends to seek an advance determination of provider-based status for the facility or organization under paragraph (b)(3) of this section or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a freestanding facility.

(ii) If the provider indicates that it will not be seeking an advance determination for the facility or organization under paragraph (b) of this section or that the facility or organization or its practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (j)(5) will end as of the 30th day after the date of notice.

(iii) If the provider indicates that it will be seeking an advance determination for the facility or organization under paragraph (b) of this section or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(4) of this section, for as long as is required for all billing requirements to be met (but not longer than 6 months) if the provider or the facility or organization or its practitioners—

(A) Submits, as applicable, a complete request for an advance determination of provider-based status or a complete enrollment application and provide all other required information within 90 days after the date of notice; and

(B) Furnishes all other information needed by CMS to process the request for provider-based status or the enrollment application, as applicable,

and verifies that other billing requirements are met.

(v) If the necessary applications or information are not provided, CMS will terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

(k) *Temporary treatment as provider-based and correction of errors.* (1) If a provider submits a complete request for a provider-based determination for a facility or organization that has not previously been found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section, the provider may bill and be paid for services of the facility or organization as provider-based from the date of the application until the date that CMS determines that the facility or organization does not meet the provider-based rules. If CMS subsequently determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the complete request for a provider-based determination was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements. For purposes of this paragraph (k), a complete request is one that includes all information needed to permit CMS to make an advance determination under paragraph (b)(3) of this section.

(2) If CMS determines that a facility or organization that had previously been determined to be provider-based under paragraph (b) of this section no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did report to CMS as required under paragraph (c) of this section, treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.

(3) If CMS determines that a facility or organization that had previously been determined to be provider-based under paragraph (b) of this section no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS, as required under paragraph (c) of this section, CMS will take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in paragraphs (j)(3), (j)(4), and (j)(5) of this section, and will recover past payments to the provider to the extent described in paragraph (j)(1)(ii) of this section.

* * * * *

(m) *FQHCs and ''look alikes''.* * * *

(n) *Effective date of provider-based status.* Provider-based status for a facility or organization is effective on the earliest date on which a request for provider-based status, as described in paragraph (b) of this section, has been made and all of the requirements of this part have been met.

3. Section 413.70 is amended by revising paragraph (b)(3)(i) to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) *Payment for outpatient services furnished by CAH.*

* * * * *

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section. This election must be made in writing, made on an annual basis, and delivered to the intermediary servicing the CAH by a date determined by that intermediary, which may be no less than 14 days and no more than 60 days before the start of each affected cost reporting period. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

* * * * *

4. Section 413.86 is amended by—

A. Adding a definition of ''Affiliation agreement'' in alphabetical order under paragraph (b).

B. Revising the last sentence of the introductory text of paragraph (e)(5)(i).

C. Revising paragraph (e)(5)(i)(B).

D. Adding a new paragraph (e)(5)(i)(C).

E. Redesignating paragraphs (g)(5)(iv), (g)(5)(v), and (g)(5)(vi) as paragraphs (g)(5)(v), (g)(5)(vi), and (g)(5)(vii), respectively.

F. Republishing the introductory text of paragraph (g)(5) and adding a new paragraph (g)(5)(iv).

G. Redesignating paragraphs (g)(7) through (g)(12) as paragraphs (g)(8) through (g)(13), respectively.

H. Adding a new paragraph (g)(7).

I. Making the following cross-reference changes:

i. In redesignated paragraph (g)(5)(vii), ''paragraph (g)(8)'' is removed and ''paragraph (g)(9)'' is added in its place.

ii. In paragraph (g)(6), ''paragraph (g)(12)'' is removed and ''paragraph (g)(13)'' is added in its place.

iii. In redesignated paragraphs (g)(8)(iv) and (g)(8)(v), ''paragraph (g)(7)'' is removed and ''paragraph (g)(8)'' is added in its place.

iv. In redesignated paragraph (g)(9)(i), ''paragraph (g)(8)'' is removed and ''paragraph (g)(9)'' is added in its place.

v. In the introductory text of redesignated paragraph (g)(9)(iii), ''paragraph (g)(8)(iii)(B)'' is removed and ''paragraph (g)(9)(iii)(B)'' is added in its place; and ''paragraph (g)(8)(iii)(A)'' is removed and ''paragraph (g)(9)(iii)(A)'' is added in its place.

vi. In redesignated paragraph (g)(9)(iii)(A)(*2*), ''paragraph (g)(8)(iii)(B)(*2*)'' is removed and ''paragraph (g)(9)(iii)(B)(*2*)'' is added in its place.

vii. In the introductory text of redesignated paragraph (g)(12), ''paragraph (g)(11)(i) through (g)(11)(vi)'' is removed and ''paragraph (g)(12)(i) through (g)(12)(vi)'' is added in its place.

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

Affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group, as defined in this section, that specifies—

(1) The term of the agreement (which, at a minimum is one year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect FTE caps existing at the time of affiliation;

(3) The adjustment to each hospital's FTE caps in each year that the affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount; and

(4) The names of the participating hospitals and their Medicare provider numbers.

* * * * *

(e) *Determining per resident amounts for the base period.* * * *

(5) *Exceptions*—(i) *Base period for certain hospitals.* * * The per

resident amount is based on the lower of the amount specified in paragraph (e)(5)(i)(A) or in paragraph (e)(5)(i)(B) of this section, subject to the provisions of paragraph (e)(5)(i)(C) of this section.

* * * * *

(B) Except as specified in paragraph (e)(5)(i)(C) of this section—

(*1*) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter.

(*2*) For base periods beginning on or after October 1, 2002, the weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(C) If, under paragraph (e)(5)(i)(B)(*1*) or (e)(5)(i)(B)(*2*) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

* * * * *

(g) *Determining the weighted number of FTE residents.* * * *

(5) For purposes of determining direct graduate medical education payment—

* * * * *

(iv) Hospitals that are part of the same affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

* * * * *

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in an affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the affiliated group must submit the affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.

(ii) There must be a rotation of a resident(s) among the hospitals participating in the affiliated group during the term of the affiliation agreement such that more than one of the hospitals count the proportionate amount of the time spent by the resident(s) in their FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(iii) The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.

(iv) If the affiliation agreement terminates for any reason, the FTE cap of each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (g)(4) of this section.

* * * * *

PART 482—CONDITIONS FOR PARTICIPATION FOR HOSPITALS

D. Part 482 is amended as follows:

1. The authority citation for part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1320 and 1395hh).

2. Section 482.12 is amended by adding a new paragraph (f)(3), to read as follows:

§ 482.12 Condition of participation: Governing body.

* * * * *

(f) *Standard: Emergency services.*

* * *

(3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

E. 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 1396hh).

2. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised, to read as follows.

§ 485.645 Special requirements for CAH providers of long-term care services (''swing-beds'').

* * * * *

(d) *SNF services.* The CAH is substantially in compliance with following SNF requirements contained in subpart B of part 483 of this chapter.

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under § 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b) of this chapter).

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

F. Part 489 is amended as follows:

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Act (42 U.S.C. 1302 and 1395hh).

2. Section 489.24 is amended by—

A. Revising paragraph (a).

B. Republishing the introductory text of paragraph (b) and revising the definitions of ''Comes to the emergency department'' and ''Hospital with an emergency department''.

C. Adding definitions of ''Dedicated emergency department'', ''Hospital property'', and ''Patient'' in alphabetical order under paragraph (b).

D. Under the definition of ''Emergency medical condition'' under paragraph (b), redesignating paragraphs (i), (i)(A), (i)(B), (i)(C), (ii), (ii)(A), and (ii)(B) as paragraphs (1), (1)(i), (1)(ii), (1)(iii), (2), (2)(i), and (2)(ii), respectively.

E. Under the definition of ''Participating hospital'' under paragraph (b), redesignating paragraphs (i) and (ii) as paragraphs (1) and (2), respectively.

F. Under the definitions of ''Stabilized'' and ''To stabilize'' under paragraph (b), ''paragraph (i)'' is removed and ''paragraph (1)'' is added in its place; and ''paragraph (ii)'' is removed and ''paragraph (2)'' is added in its place.

G. Removing paragraph (i); and redesignating paragraph (c) through (h) as paragraphs (d) through (i), respectively.

H. Adding a new paragraph (c).

I. Revising newly redesignated paragraph (d).

J. Adding a new paragraph (j).

K. Making the following cross-reference changes:

i. In redesignated paragraph (e)(1)(i), ''paragraph (d)(2)'' is removed and ''paragraph (e)(2)'' is added in its place.

ii. In redesignated paragraph (e)(1)(ii)(C), ''paragraph (d)(1)(ii)(B)'' is removed and ''paragraph (e)(1)(ii)(B)'' is added in its place.

iii. In redesignated paragraph (e)(2)(iii), ''paragraph (d)(1)(ii)'' is removed and ''paragraph (e)(1)(ii)'' is added in its place.

iv. In redesignated paragraph (e)(2)(iii), ''paragraph (f)'' is removed and ''paragraph (g)'' is added in its place.

v. In redesignated paragraph (e)(3), ''paragraph (d)(1)(ii)(C)'' is removed and ''paragraph (e)(1)(ii)(C) is added in its place.

vi. In redesignated paragraph (g), ''paragraph (a) through (e)'' is removed and ''paragraphs (a) through (f)'' is added in its place.

vii. In redesignated paragraph (h)(1), ''paragraph (g)(3)'' is removed and ''paragraph (h)(3)'' is added in its place; and ''paragraph (g)(2)(iv) and (v)'' is removed and ''paragraphs (h)(2)(iv) and (v)'' is added in its place.

viii. In redesignated paragraph (h)(2) introductory text, ''paragraph (g)(1)'' is removed and ''paragraph (h)(1)'' is added in its place.

ix. In redesignated paragraph (h)(2)(iii)(B), ''paragraph (g)(2)(iii)(A)'' is removed and ''paragraph (h)(2)(iii)(A)'' is added in its place.

x. In redesignated paragraph (h)(2)(vi), ''paragraph (g)(2)(v)'' is removed and ''paragraph (h)(2)(v)'' is added in its place.

xi. In redesignated paragraph (h)(4), ''paragraph (g)'' is removed and ''paragraph (h)'' is added in its place; and ''paragraph (g)(2)(v)'' is removed and ''paragraph (h)(2)(v)'' is added in its place.

The additions and revisions read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Application.* In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) ''comes to the emergency department'', as defined in paragraph (b) of this section, the hospital must—

(1) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) determined qualified by hospital bylaws or rules and regulations and who meet the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and

(2) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section.

(b) *Definitions.* As used in this subpart—

* * * * *

Comes to the emergency department means, with respect to an individual who is not a patient, the individual—

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf (except for certain outpatients as specified in paragraph (d)(3) of this section). In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in an ambulance owned and operated by the hospital for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. This provision does not apply if the ambulance is operating under communitywide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the nearest hospital. In this latter case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property; or

(4) Is in a nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In the latter circumstance, the hospital may deny access if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means a specially equipped and staffed area of the hospital that is used a significant portion of the time for the initial evaluation and treatment of outpatients for emergency medical conditions, as defined in this section, and that is located—

(1) On the main hospital campus; or

(2) Off the main hospital campus and is treated by Medicare under § 413.65(b) of this chapter as a department of the hospital.

* * * * *

Hospital property means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures that are located within 250 yards of the hospital's main building but are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital that offers services for emergency medical conditions (as defined in this paragraph (b)) within its capability to do so, including a hospital that offers these services at locations other than its main hospital campus.

* * * * *

Patient, for purposes of this section, means an individual who is either an outpatient as defined in § 410.2 of this chapter, or is receiving inpatient hospital services as defined in § 409.10(b) of this chapter.

* * * * *

(c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions.*—(1) *General.* If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition; or

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Application to inpatients—admitted emergency patients.*

(i) When an individual has been screened under paragraph (a) of this section and found to have an emergency medical condition, and the individual has not been stabilized as defined in paragraph (b) of this section, the provisions of this section would apply, even if the hospital admits the patient as an inpatient. Admitting an individual whose emergency medical condition has not been stabilized does not relieve the hospital of further responsibility to the individual under this section.

(ii) If a hospital admits an individual with an unstable emergency medical condition for stabilizing treatment, as an inpatient, stabilizes that individual's emergency medical condition, and this period of stability is documented by relevant clinical data in the individual's medical record, the hospital has satisfied its special responsibilities under this section with respect to that individual. If the patient is stable for a transfer of the type usually undertaken with respect to patients having the same medical conditions, the hospital's special responsibilities under this section are satisfied, even if no transfer occurs and the individual remains at the hospital as an inpatient for followup care. If, after stabilization, the individual who was admitted as an inpatient again has an apparent decline of his or her medical condition, either as a result of the injury or illness that created the emergency for which he or she initially came to the dedicated emergency department or as a result of another injury or illness, the hospital must comply with the conditions of participation for hospitals under part 482 of this chapter but has no further responsibility under this section with respect to the individual.

(iii) A hospital has no responsibility under this section with respect to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. If such an inpatient has an abrupt deterioration of his or her medical condition after admission, the hospital must comply with the conditions of participation for hospitals under part 482 of this chapter and is not required to comply with the special responsibilities of this section.

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.* (i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraphs (d)(1) and (d)(2) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct a patient to seek, authorization from the individual's insurance company for screening or stabilization services to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraphs (d)(1) and (d)(2) of this section.

(iii) An emergency physician is not precluded from contacting the patient's physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(5) *Refusal to consent to transfer.* A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(6) *Hospital responsibility for communication with Medicare+Choice organizations after stabilization of an emergency medical condition.* When an enrollee of a Medicare+Choice organization who is treated for an emergency medical condition is stabilized and needs further hospital care, the hospital must promptly contact the Medicare+Choice organization to obtain preapproval of the further hospital care, consistent with the provisions of § 422.113 of this chapter.

* * * * *

(j) *Availability of on-call physicians.* Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients. Physicians, including specialists and subspecialists, are not required to be on call at all times. The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: April 24, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 26, 2002.

Tommy G. Thompson,

Secretary.

[**Editorial Note:** The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges Occurring On or After October 1, 2002 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2002

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system.

For discharges occurring on or after October 1, 2002, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the acute care hospital inpatient 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 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or 75 percent of the updated hospital-specific rate based on FY 1996 costs per discharge, plus the greater of 25 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 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher.

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 proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2003. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2002, would affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2003. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2003. The tables to which we refer in the preamble to this final rule are presented at the end of this Addendum in section V.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2003

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section V. 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 the proposed DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2002 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2002 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) contained a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the acute care hospital inpatient prospective payment system.

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 require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the acute care hospital inpatient 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 acute care hospital inpatient prospective payment system. As discussed in section IV. of the preamble to this proposed rule, we are proposing to revise the labor share of the standardized amount (the proportion adjusted by the wage index) to be 72.5 percent. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 2001 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 the latest available population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2003. 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 proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2003 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVIII) of the Act specifies that the update factor for the standardized amounts for FY 2003 is equal to the market basket percentage increase minus 0.55 percentage points for hospitals in all areas.

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 2003 is 3.3 percent. Thus, for FY 2003, 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 2002 standardized amounts to remove the effects of the FY 2002 geographic reclassifications and outlier payments before applying the FY 2003 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 2003.

Although the update factors for FY 2003 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 2003 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix B to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix C to this proposed 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. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

We note, however, that 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. This provision is required by section 4410(b) of Public Law 105–33 to be budget neutral.

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 2001 discharge data to simulate payments and compared aggregate payments using the FY 2002 relative weights and wage index to aggregate payments using the proposed FY 2003 relative weights and wage index. The same methodology was used for the FY 2002 budget neutrality adjustment. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.001026. 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 1.002689. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2002 budget neutrality adjustments. 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 are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2002. (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 acute care hospital inpatient 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 2001 discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying a proposed adjustment factor of 0.990536 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 2002 budget neutrality adjustment factor. We note that the proposed FY 2003 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 28, 2002, 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 occur as a result of appeals and reviews of the MGCRB decisions for FY 2003 or from a hospital's request for the withdrawal of a reclassification request for FY 2003 will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the final rule for FY 2003.

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). To qualify for outlier payments, a case must have costs above a threshold amount. To determine whether the costs of a case exceed the threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce 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 reduce 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.

i. FY 2003 outlier thresholds. For FY 2002, the threshold was equal to the prospective payment rate for the DRG plus any IME and DSH payments plus $21,025. 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 2003, we are proposing to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME and DSH payments, and any add-on payments for new technology, plus $33,450. This single threshold would be applicable to qualify for both operating and capital outlier payments. We are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

To calculate the proposed FY 2003 outlier thresholds, we simulated payments by applying proposed FY 2003 rates and policies to the December 2001 update of the FY 2001 MedPAR file and the December 2001 update of the Provider-Specific File. Therefore, it is necessary to inflate the charges on the MedPAR claims by 2 years.

Previously, inflation factors have been calculated by measuring the percent change in costs using the two most recent available cost report files. For example, the FY 2002 threshold was determined using the rate of cost increase measured using costs from hospitals' FY 1998 and FY 1999 cost reports. However, at the time of this proposed rule, the FY 2000 cost reports are not available to produce an updated cost inflation factor due to processing delays associated with implementing the hospital outpatient prospective payment system.

Rather than use the rate of cost increase from hospitals' FY 1998 and FY 1999 cost reports to project the rate of increase from FY 2001 to FY 2003, we are proposing to use a 3-year moving average of the rate of change in prior years to estimate the annual rates of increase from FY 2001 to FY 2003. The calculation is shown in the table below.

For example, the rate of change in cost per case from 1998 to 1999 was 1.0242 percent. This rate of change is then subtracted by the rate of change from 1997 to 1998 (1.0237) to calculate a difference in change of 0.005. A 3-year average of the annual rates of change was then computed based on the difference in the percent changes from the 3 most recent prior years. The difference in change for 1997 to 1998 is then averaged with the differences for 1996 to 1997, and for 1995 to 1996, to calculate a 3-year average of 0.0180. To project percent changes in costs for FY 2000 through FY 2003, the average of the differences in the percent changes for the 3 most recent years (0.0180) was added to the percent change in cost per case for the previous year (1.0242) to estimate the percent change in costs between fiscal years. This proposed methodology resulted in an estimated change of 1.066 (6.6 percent increase) for FY 2001 to FY 2002 and 1.079 (7.9 percent increase) for FY 2002 to FY 2003.

Cost reports begin in FY	Cost/case	Rate of change in cost per case	Difference in change	3-year moving average of differences in change
1995	5818.50	.....	.....	.....
1996	5644.52	0.9701	.....	.....
1997	5666.03	1.0038	0.0337	.....
1998	5800.34	1.0237	0.0199	.....
1999	5940.85	1.0242	0.0005	.....
2000	.....	1.0423	0.0180	0.0180
2001	.....	1.0551	0.0128	0.0128
2002	.....	1.0655	0.0105	0.0105
2003	.....	1.0793	0.0138	0.0138

Based on this proposed methodology, we are proposing a 2-year cost inflation factor of 15.0 percent to inflate FY 2001 charges to FY 2003, determined by multiplying the annual projected inflation factors for FYs 2002 and 2003 of 1.0655 and 1.0793.

Using FY 2001 cases now available, our analysis indicates that this 3-year moving average methodology would have resulted in FY 2002 outlier payments very close to 5.1 percent of total operating DRG payments and outlier payments (the current projection of FY 2002 outlier payments is 6.8 percent of total DRG and outlier payments—see discussion below). We intend to update our analysis of FY 2002 outlier payments using actual FY 2002 claims available through March 2002 prior to publishing the final rule by August 1.

We want to emphasize that we are making this proposal due to the unavailability of the FY 2000 cost reports. If the proposed methodology is ultimately adopted in the final rule for FY 2003, this would not necessarily mean that we would apply the same methodology in future fiscal years when updated cost report information becomes available.

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 operating DRG payments plus outlier payments. In accordance with section 1886(d)(3)(B), we reduced the proposed FY 2003 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 hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2003 would result in outlier payments equal to 5.1 percent of operating DRG payments and 5.4 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2003 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.949004	0.945957
Puerto Rico	0.982910	0.980994

We apply the outlier adjustment factors after removing the effects of the FY 2002 outlier adjustment factors on the standardized amounts.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios, then these costs are combined to compare with the fixed-loss outlier threshold.

For those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.200 or greater than 1.262, or capital cost-to-charge ratios lower than 0.012 or greater than 0.167, statewide average ratios would be used to calculate costs to determine whether a hospital qualifies for outlier payments.[1] Table 8A in section V. of this Addendum contains the proposed statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios would replace the

[1] 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.

ratios published in the August 1, 2001 final rule (66 FR 40083). Table 8B contains comparable statewide average capital cost-to-charge ratios. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2003 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the three standard deviations range.

iii. FY 2001 and FY 2002 outlier payments. In the August 1, 2001 final rule (66 FR 39942), we stated that, based on available data, we estimated that actual FY 2001 outlier payments would be approximately 6.2 percent of actual total DRG payments. This was computed 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). That is, the estimate of actual outlier payments did not reflect actual FY 2001 bills but instead reflected the application of FY 2001 rates and policies to available FY 2000 bills.

Our current estimate, using available FY 2001 bills, is that actual outlier payments for FY 2001 were approximately 7.6 percent of actual total DRG payments. Thus, the data indicate that, for FY 2001, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2001 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2001). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the acute care hospital inpatient prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 2001. We note that the MedPAR file for FY 2001 discharges continues to be updated, and we will update our estimate of actual FY 2001 outlier payments as a percentage of total payments in the final rule.

We currently estimate that actual outlier payments for FY 2002 will be approximately 6.8 percent of actual total DRG payments, 1.7 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2002. This estimate is based on simulations using the December 2001 update of the Provider-Specific File and the December 2001 update of the FY 2001 MedPAR file (discharge data for FY 2001 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2002 by applying FY 2002 rates and policies to available FY 2001 bills.

5. FY 2003 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A contains the two national standardized amounts that we are proposing to be applicable to all hospitals, except hospitals in Puerto Rico. As described in section II.A.1. of this Addendum, we are proposing to revise the labor share of the national standardized amount from 71.1 percent to 72.5 percent.

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. The labor share applied to the Puerto Rico standardized amount is 71.3 percent.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that are proposed to 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 proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of this preamble, we discuss the data and methodology for the proposed FY 2003 wage index. The proposed wage index is set forth in Tables 4A, 4B, 4C, and 4F of this Addendum. In section IV. of this preamble we discuss our proposed revised estimate of the labor-related portion of the standardized amounts.

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 2003, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2002, we will publish them in the final rule and use them in determining FY 2003 payments.

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 V. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2003. These factors have been recalibrated as explained in section II. of the preamble.

D. Calculation of Prospective Payment Rates for FY 2003

General Formula for Calculation of Prospective Payment Rates for FY 2003

The operating prospective payment rate for all hospitals paid under the acute-care, short-term inpatient prospective payment system located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the amounts in Table 1A.

For FY 2003, 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, 75 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 25 percent of the updated FY 1982 or FY 1987 hospital-specific rate, or 25 percent of the Federal rate. Section 1886(b)(3) of the Act, as amended, allows 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 proposed prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of the national rate from Table 1C.

1. Federal Rate

For discharges occurring on or after October 1, 2002 and before October 1, 2003, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the acute-care inpatient prospective payment system 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 location of the hospital (large urban or other) (see Table 1A in section V. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section V. 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 V. of this Addendum).

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 costs per discharge, the updated hospital-specific rate based on FY 1987 costs per discharge, or, for FY 2003, 75 percent of the updated hospital-specific rate based on FY 1996 costs per discharge, plus the greater of 25 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 25 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 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). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by 1.001026) 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 would be paid for its discharges beginning on or after October 1, 2002.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2003

We are proposing to increase 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 2003. 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 2003, 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 2003, is the market basket rate of increase minus 0.55 percentage points.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2002 and Before October 1, 2003

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 V. 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 V. 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 V. 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 V. 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. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2003

The prospective payment system for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital 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 in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2003, which will be effective for discharges occurring on or after October 1, 2002. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.324(b) and under proposed § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the 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. As we explained in section VI.D. of the preamble of this proposed rule, 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 during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors. As we explained in the August 1, 2001 final rule (66 FR 39911), beginning in FY 2003 an adjustment for regular exceptions is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Since payments are no longer being made under the regular exceptions policy in FY 2003, we are no longer using the capital cost model. The capital cost model and its application during the transition

period are described in Appendix B of the August 1, 2001 final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for acute care hospital 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 acute care hospital inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the August 1, 2001 final rule (66 FR 39947), we established a Federal rate of $390.74 for FY 2002. As a result of the changes we are proposing to the factors used to establish the Federal rate in this addendum, the proposed FY 2003 Federal rate is $408.90.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2003 Federal rate. In particular, we explain why the FY 2003 Federal rate has increased 4.6 percent compared to the FY 2002 Federal rate (published in the August 1, 2001 final rule (66 FR 39947)). We also estimate aggregate capital payments will increase by 5.72 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 more than last year (4.27 percent) mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate (see section VI.D. of the preamble of this proposed rule).

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 2003 compared to FY 2002.

1. Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and other factors. The update framework consists of a 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 update factor for FY 2003 under that framework is 1.1 percent. This update factor is based on a projected 0.7 percent increase in the CIPI, a 1.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a −-0.3 percent adjustment for the FY 2001 DRG reclassification and recalibration, and a forecast error correction of −0.3 percent. We explain the basis for the FY 2003 CIPI projection in section III.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the acute care hospital inpatient 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 2001 DRG reclassification and recalibration as part of our FY 2003 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2003, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2003. Therefore, the net adjustment for case-mix change in FY 2003 is 0.0 percentage points.

We estimate that FY 2001 DRG reclassification and recalibration will result in a 0.3 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 −0.3 percent adjustment for DRG reclassification and recalibration in the update recommendation for FY 2003.

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 2001 update. That is, current historical data indicate that the forecasted FY 2001 CIPI used in calculating the FY 2001 update factor (0.9 percent) overstated the actual realized price increases (0.6 percent) by 0.3 percentage points. This over-prediction was due to prices from municipal bond yields declining faster than originally expected. Therefore, we are making a −0.3 percent adjustment for forecast error in the update for FY 2003.

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 2003, we have developed a Medicare-specific intensity measure based on a 5-year average, using FY 1997 through 2001 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.3 percent in FY 1997, −0.4 percent in FY 1998, −0.3 percent in FY 1999, −0.7 in FY 2000, and −0.3 percent in FY 2001. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1997 through FY 2001. Since we did not find an increase in case-mix outside of the range of 1.0 to 1.4 percent, we believe that all of the observed case-mix increase for FYs 1997 through 2001 is real. Therefore, there was no need to employ the upper bound of 1.0 and 1.4 supported by the RAND study as we have done in the past since we did not find an increase in case-mix that 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. We estimate that case-mix constant intensity increased by an average of 1.0 percent during FYs 1997 through 2001, for a cumulative increase of 5.2 percent, given estimates of real case-mix of 0.3 percent for FY 1997, −0.4 percent for FY 1998, −0.3 percent for FY 1998, −0.7 percent for FY 2000, and −0.3 percent for FY 2001. Since we estimate that intensity has increased during that period, we are recommending a 1.0 percent intensity adjustment for FY 2003.

Above we described the basis of the components used to develop the proposed 1.1 percent capital update factor for FY 2003 as shown in Table 1 below.

TABLE 1.—CMS'S PROPOSED FY 2003 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE—

Capital Input Price Index	0.7
Intensity:	1.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−1.0
Real Across DRG Change	1.0
Subtotal	0.0
Effect of FY 2001 Reclassification and Recalibration	−0.3
Forecast Error Correction	−0.3
Total Proposed Update	1.1

b. Comparison of CMS and MedPAC Update Recommendations

In the past, MedPAC has included an update recommendation for capital prospective payment system payments in a Report to Congress. In its March 2001 report, MedPAC presented a combined operating and capital update for hospital inpatient prospective payment systems for FY 2002. Currently, section 1886(b)(3)(B)(i)(XVIII) of the Act sets forth the FY 2003 percentage increase in prospective payment system operating cost standardized amounts. The prospective payment system capital update is set at the discretion of the Secretary under the framework outlined in § 412.308(c)(1). In its March 2002 Report to Congress, MedPAC did not make an update recommendation for capital prospective payment system payments. MedPAC states that, with the two updates (operating and capital) remaining separate, it focused on the operating update since it involves more money (92 percent of hospital's Medicare costs) and it commands the most attention in Congress (page 65).

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, 2001 final rule, we estimated that outlier payments for capital in FY 2002 would equal 5.76 percent of inpatient capital-related payments based on the Federal rate (66 FR 39948). Accordingly, we applied an outlier adjustment factor of 0.9424 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 5.40 percent of inpatient capital-related payments based on the Federal rate in FY 2003. Therefore, we are proposing an outlier adjustment factor of 0.9460 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2003 is lower than the percentage for FY 2002.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net proposed change in the outlier adjustment to the Federal rate for FY 2003 is 1.0038 (0.9460/0.9424). The outlier adjustment increases the proposed FY 2003 Federal rate by 0.38 percent compared with the FY 2002 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exceptions payment adjustment factor. As we explain below in section III.A.4. of this Addendum, beginning in FY 2003 an adjustment for regular exceptions is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions adjustment factor for special exception payments.

To determine the proposed factors for FY 2003, we compared (separately for the national rate and the Puerto Rico rate) estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 GAF to estimated aggregate Federal rate payments based on the FY 2003 relative weights and the FY 2003 GAF. For FY 2002, the budget neutrality adjustment factors were 0.9927 for the national rate and 0.9916 for the Puerto Rico rate (see the August 1, 2001 final rule (66 FR 40101)). In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, we propose to apply an incremental budget neutrality adjustment of 0.9990 for FY 2003 to the previous cumulative FY 2002 adjustment of (0.9927), yielding a proposed cumulative adjustment of 0.9917 through FY 2003. For the Puerto Rico GAF, we propose to apply an incremental budget neutrality adjustment of 1.0080 for FY 2003 to the previous cumulative FY 2002 adjustment (0.9916), yielding a proposed cumulative adjustment of 0.9996 through FY 2003.

We then compared estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 GAF to estimated aggregate Federal rate payments based on the proposed FY 2003 DRG relative weights and the FY 2003 GAF. The proposed incremental adjustment for DRG

classifications and changes in relative weights is 1.0034 nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2003 are 0.9951 nationally and 1.0030 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			
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	Cumulative
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99846	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
2003	[5]0.99902	[5]1.00342	[5]1.00244	[5]0.99510	[5]1.00804	[5]1.00342	[5]1.01149	[5]1.00303

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Proposed factors for FY 2003.

The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2003 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 GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

For FY 2002, we calculated a GAF/DRG budget neutrality factor of 0.9934. For FY 2003, we are proposing a GAF/DRG budget neutrality factor of 1.0024. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 2002 to FY 2003 is 1.0024. The proposed cumulative change in the rate due to this adjustment is 0.9951 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, and the proposed incremental factor for FY 2003: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 1.0024 = 0.9951$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2003 geographic reclassification decisions made by the MGCRB compared to FY 2002 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital 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 actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)) to determine the exception adjustment factor, which was applied to both the Federal and hospital-specific rates.

An adjustment for regular exceptions is no longer necessary in determining the proposed FY 2003 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 final rule (66 FR 39949), in FY 2003 and later, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in establishing the FY 2003 proposed capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special 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 as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

As we explained in the August 1, 2001 final rule (66 FR 39912 through 39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special 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 the 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, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2001.

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 added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least $200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 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 ignored 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 payment, 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).

Our modeling of special exception payments for FY 2003 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX	.....	.....
PPS X	.....	.....
PPS XI	2	.....
PPS XII	6	0.0002
PPS XIII	8	0.0001
PPS XIV	16	0.0003
PPS XV	20	0.0011
PPS XVI	28	0.0019

We note that 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, and therefore, we 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 could be approximately 0.0040.

Because special exceptions are budget neutral, we propose to offset the proposed Federal capital rate by 0.40 percent for special exceptions for FY 2003. Therefore, the proposed exceptions adjustment factor for special exception payments would equal 0.9960 (1 − 0.0040) to account for special exception payments in FY 2003. We will revise this projection of the special exception adjustment factor in the final rule based on the latest available data.

For FY 2002, we estimated that total (regular and special) exceptions payments would equal 0.71 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9929 (1 − 0.0071) in determining the Federal rate. As we stated above, we estimate that exceptions payments for FY 2003 will equal 0.40 percent of aggregate payments based on the Federal rate. Therefore, we are proposing an exceptions payment reduction factor of 0.9960 (1 − 0.0040) to the Federal rate for FY 2003. The proposed exceptions reduction factor for FY 2003 is 0.31 percent higher than the factor for FY 2002 published in the August 1, 2001 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. Therefore, the proposed net change in the exceptions adjustment to the FY 2003 Federal rate is 0.9960/0.9929, or 1.0031.

5. Special Adjustment To Restore the 2.1 Percent Reduction to the Standard Federal Capital Prospective Payment System Payment Rate

As we explained in section VI.D. of the preamble of this proposed rule, section 1886(g)(1)(A) of the Act, as amended by section 4402 of Public Law 105–33, requires the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate by 2.1 percent for discharges on or after October 1, 1997, and through September 30, 2002. Therefore, under the statute the additional 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002. Accordingly, we are proposing to revise § 412.308(b) to restore the 2.1 percent reduction to the unadjusted standard Federal capital prospective payment system payment rate for discharges occurring on or after October 1, 2002 to the level that it would have been without the reduction.

As we state in section VI.D. of the preamble of this proposed rule and in the August 29, 1997 final rule (62 FR 46012), we applied a factor of 0.8222 in FY 1998 to account for both the reduction equal to the FY 1995 budget neutrality factor (0.1568) and the 2.1 percent reduction (0.021) provided for under section 4402 of Public Law 105–33. In order to determine the adjustment factor needed to restore the 2.1 percent reduction, we would divide the amount of the adjustment without the 2.1 percent reduction (1 − 0.1568 = 0.8432) by the amount of the adjustment with the 2.1 percent reduction (0.8222). Therefore, we are proposing to apply a factor of 1.02554 (0.8432/0.8222) to the unadjusted FY 2002 standard Federal capital prospective payment system payment rate to restore the 2.1 percent reduction for discharges occurring on or after October 1, 2002.

6. Standard Capital Federal Rate for FY 2003

For FY 2002, the capital Federal rate was $390.74. For FY 2003, we are proposing a capital Federal rate of $408.90. The proposed Federal rate for FY 2003 was calculated as follows:

- The proposed FY 2003 update factor is 1.0110; that is, the update is 1.10 percent.
- The proposed FY 2003 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0024.
- The proposed FY 2003 outlier adjustment factor is 0.9460.
- The proposed FY 2003 exceptions payments adjustment factor is 0.9960.
- The proposed special adjustment factor for FY 2003 to restore the 2.1 percent reduction to the standard Federal rate is 1.0255.

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 are proposing to make no additional adjustments in the standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2003 affected the computation of the proposed FY 2003 Federal rate in comparison to the FY 2002 Federal rate. The proposed FY 2003 update factor has the effect of increasing the Federal rate by 1.10 percent compared to the FY 2002 Federal rate, while the proposed geographic and DRG budget neutrality factor has the effect of increasing the Federal rate by 0.24 percent. The proposed FY 2003 outlier adjustment factor has the effect of increasing the Federal rate by 0.38 percent compared to the FY 2002 Federal rate. The proposed FY 2003 exceptions reduction factor has the effect of increasing the Federal rate by 0.31 percent compared to the exceptions reduction for FY 2002. The proposed special adjustment factor for FY 2003 to restore the 2.1 percent reduction to the standard Federal rate has the effect of increasing the Federal rate by 2.55 percent compared to the FY 2002 Federal rate. The combined effect of all the proposed changes is to increase the Federal rate by 4.65 percent compared to the FY 2002 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2002 FEDERAL RATE AND PROPOSED FY 2003 FEDERAL RATE

	FY 2002	Proposed FY 2003	Change	Percent change
Update factor [1]	1.0130	1.0110	1.0110	1.10
GAF/DRG Adjustment Factor [1]	0.9934	1.0024	1.0024	0.24
Outlier Adjustment Factor [2]	0.9424	0.9460	1.0038	0.38
Exceptions Adjustment Factor [2]	0.9929	0.9960	1.0031	0.31
Special Adjustment [3]	N/A	1.0255	1.0255	2.55
Federal Rate	$390.74	$408.90	1.0465	4.65

[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 2002 to FY 2003 resulting from the application of the 1.0024 GAF/DRG budget neutrality factor for FY 2003 is 1.0024.

[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 2003 outlier reduction factor is 0.9460/0.9424, or 1.0038.

[3] Section 1886(g)(1)(A) of the Act requires, for discharges on or after October 1, 1997, and through September 30, 2002, the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate by 2.1 percent. Thus, the 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002, and we are proposing to restore the 2.1 percent reduction by applying a factor of 1.0255 (see section VI.D. of the preamble of this proposed rule).

7. 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. As we stated in section III.A.4. of this Addendum, for Puerto Rico the proposed GAF budget neutrality factor is 1.0080, while the proposed DRG adjustment is 1.0034, for a proposed combined cumulative adjustment of 1.0115.

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 2002, before application of the GAF, the special rate for Puerto Rico hospitals was $187.73. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2003 special rate for Puerto Rico is $199.70.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2003

With the end of the capital prospective payment system transition period in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under proposed § 412.304(c)(2)) are paid based on 100 percent of the Federal rate in FY 2003. 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 2003, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2003 are in section II.A.4.c. of this Addendum. For FY 2003, 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 $33,450.

An eligible hospital may also 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 as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital 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. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology was applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.B. of the preamble of this proposed rule, we are proposing under § 412.304(c)(2) to pay new hospitals 85 percent of their reasonable costs during the first 2 years of operation. Effective with the third year of operation through the remainder of the transition period, we would pay the hospital based on 100 percent of the capital Federal (that is, the same methodology used to pay all other hospitals subject to capital prospective payment system).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1992 in the August 30, 1996 final rule (61 FR 46196). In this proposed rule, we are proposing to revise and rebase the CIPI to a FY 1997 base year to reflect the more recent structure of capital costs. For further details on the proposed rebasing and revision of the CIPI, see section IV.B. of this proposed rule.

2. Forecast of the CIPI for Federal Fiscal Year 2003

We are forecasting the proposed CIPI to increase 0.7 percent for FY 2003. This reflects a projected 1.3 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.7 percent increase in other capital expense prices in FY 2003, partially offset by a 2.2 percent decline in vintage-weighted interest rates in FY 2003. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

The inpatient operating costs of hospitals and hospital units excluded from the acute care hospital inpatient 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).

Under existing § 413.40(c)(4)(iii)(B), for cost reporting periods beginning and during FYs 1998 and through 2002, 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 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 hospitals for hospitals and hospital 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.

Under existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), effective for cost reporting periods beginning during FY 2003, payments to existing excluded hospitals and hospital units will no longer be subject to a 75th percentile cap. These excluded hospitals and hospital units will be paid based on their aggregate Medicare inpatient operating costs, which may not exceed their ceiling. The ceiling on a hospital's or hospital unit's aggregate Medicare inpatient operating costs would be computed using the hospital's or hospital unit's target amount from the previous cost reporting period updated using the rate-of-increase percentage specified in § 413.40(c)(3)(viii) and multiplied by the total number of Medicare discharges.

Section 1886(b)(3)(B) of the Act, as implemented in regulations at § 413.40(c)(3)(viii), provides that, for cost reporting periods beginning on or after October 1, 2002, the update factor for a hospital or hospital unit is the percentage increase projected by the hospital market basket index. The most recent proposed projected forecast of the market basket percentage increase for FY 2003 for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system is 3.4 percent. This proposed percentage change is made by CMS'' Office of the Actuary and reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital care. Therefore, we are proposing that the update to a hospital's target amount for its cost reporting period beginning in FY 2003 would be 3.4 percent.

As discussed in section VII. of the preamble of this proposed rule, we are proposing to make an adjustment to the updated cap on the target amounts per discharge for each class of new excluded hospitals and hospital units for cost reporting periods beginning during FY 2003, using the prospective payment system wage index without taking into account the reclassifications under sections 1886(d)(8)(B) and (d)(10) of the Act. 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.

Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units, effective October 1, 1997.

For cost reporting periods beginning in FY 2003, the proposed caps are as follows:

Class of excluded hospital or unit	FY 2003 proposed labor-related share	FY 2003 proposed nonlabor-related share
Psychiatric	$7,047	$2,801
Long-Term Care	17,269	6,866

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals and units since they will be paid under the inpatient rehabilitation facility prospective payment system.

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.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, and 10 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 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,099.62	$1,175.71	$3,050.55	$1,157.10

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large Urban Areas		Other Areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,073.03	$1,165.63	$3,073.03	$1,165.63
Puerto Rico	1,475.56	593.94	1,452.19	584.54

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$408.90
Puerto Rico	$199.70

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
010001	16.4088	17.4467	17.7070	17.1977
010004	17.9732	19.0010	20.1613	19.0027
010005	17.5985	18.6554	21.5442	19.2074
010006	16.7480	17.6115	18.6118	17.6922
010007	15.4798	15.6788	16.0781	15.7477
010008	14.7443	17.4728	19.0182	17.0908
010009	18.7731	18.4979	19.7272	18.9866
010010	16.4468	16.4664	17.7348	16.9045
010011	20.7972	22.4292	24.7067	22.5297
010012	17.7171	15.8686	20.3948	17.8168
010015	15.4510	19.1178	19.8205	18.1040
010016	17.2473	20.2198	20.4139	19.2448
010018	17.6449	18.9388	19.5519	18.7214
010019	16.3493	17.0856	17.4615	16.9602
010021	16.2919	15.1241	*	15.7091

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
010022	18.5879	17.6435	22.2036	19.2378
010023	16.1025	16.3209	18.4567	16.9929
010024	16.2900	15.9034	17.0372	16.4149
010025	15.1356	15.1548	16.9733	15.7569
010027	11.7900	16.8595	16.5157	14.5941
010029	17.6461	18.3605	19.1001	18.3671
010031	18.7835	18.6402	19.2612	18.9043
010032	12.5995	15.3590	16.3967	14.8530
010033	20.3923	21.2986	21.8375	21.1715
010034	15.0959	15.3639	14.9379	15.1325
010035	20.1853	15.9439	20.8498	18.7765
010036	17.8140	17.7166	18.1325	17.8864
010038	18.2671	19.6098	19.6887	19.2225
010039	20.1045	20.3406	21.1309	20.5522
010040	18.9376	20.0983	20.4032	19.7634
010043	30.7489	18.6640	18.1128	21.1242
010044	22.0091	24.0265	23.4575	23.1128
010045	15.2200	17.0417	18.7569	16.8822
010046	17.3970	18.9737	18.8741	18.4218
010047	13.3521	15.4190	13.4130	14.0833
010049	14.7590	15.5246	16.3349	15.5762
010050	18.5163	17.9830	20.3028	18.9035
010051	11.9275	11.8108	12.3280	12.0151
010052	16.5486	18.0653	19.8289	18.3581
010053	14.6267	15.5649	15.4156	15.2353
010054	18.5103	19.4955	20.9656	19.7134
010055	18.9526	18.8590	19.4959	19.1060
010056	19.2175	19.6577	20.5645	19.7867
010058	16.1702	16.9715	16.1265	16.4288
010059	19.1286	18.8020	19.1270	19.0199
010061	14.9547	14.5003	18.5320	15.9823
010062	14.7732	12.3259	*	13.4892
010064	20.4139	19.5256	20.6628	20.1862
010065	16.4049	16.8752	18.8957	17.4231
010066	15.4317	13.1559	14.8904	14.4355
010068	12.0525	18.6925	23.4322	17.0157
010069	13.8636	14.7211	15.4497	14.6885
010072	14.9526	16.2339	16.5652	15.9117
010073	13.8601	14.1273	13.5594	13.8482
010078	17.9202	18.1363	18.5127	18.1930
010079	16.4421	17.0648	16.8045	16.7705
010081	18.9474	17.2996	*	18.1637
010083	16.8933	18.0312	18.4282	17.8382
010084	18.4965	18.7769	19.8773	19.0316
010085	18.4744	19.9023	21.3593	19.9065
010086	16.6694	16.5711	16.8886	16.7103
010087	19.0033	18.0567	18.6860	18.6208
010089	16.8042	17.7800	19.5697	18.0246
010090	18.3866	18.9445	19.5635	18.9671
010091	13.9405	17.0799	17.1775	15.9756
010092	16.9900	17.8144	18.5703	17.8203
010095	12.4525	12.2597	13.7865	12.8381
010097	13.0413	12.7286	14.2675	13.3206
010098	15.9165	14.0300	15.5763	15.1201
010099	15.9874	15.5619	15.9232	15.8146
010100	17.2011	17.9430	18.3755	17.8826
010101	15.3859	14.4625	18.7988	16.0267
010102	13.7933	13.8136	15.7777	14.4205
010103	17.9358	17.7242	22.2456	19.1327
010104	17.7126	16.8457	22.0038	18.6396
010108	17.9017	19.4617	19.1596	18.8606
010109	15.3107	14.6752	15.9627	15.2873
010110	15.6317	15.8283	15.5817	15.6824

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
010112	15.1401	16.8271	15.6041	15.8270
010113	16.9683	16.8936	18.2706	17.3693
010114	15.2454	17.0760	19.0678	17.1007
010115	14.6268	14.2261	15.3510	14.7053
010118	18.8477	17.0834	17.4620	17.7157
010119	18.8024	19.3942	19.4672	19.3127
010120	17.2336	18.2567	18.9975	18.1726
010121	14.6444	14.5262	15.2345	14.7784
010123	16.7344	19.2140	*	17.9083
010124	16.2846	16.7465	*	16.5122
010125	15.5304	16.0136	16.5117	16.0174
010126	19.5710	19.1065	19.5933	19.4288
010127	19.5190	18.2786	*	18.9233
010128	14.5056	14.4322	15.1184	14.6873
010129	14.7286	16.1733	16.7609	15.8741
010130	16.6809	19.5573	17.4614	17.7942
010131	17.8260	20.1883	19.0492	18.9966
010134	18.8835	19.9856	18.5179	19.1797
010137	12.1217	20.5828	21.3573	17.6481
010138	12.8675	14.5254	14.1369	13.8739
010139	19.0001	20.4331	20.5708	19.9541
010143	16.7911	17.6212	18.8903	17.7663
010144	17.1320	18.2040	18.7743	18.0281
010145	20.8434	20.5895	20.8110	20.7460
010146	18.5198	19.1415	18.3666	18.6687
010148	12.2214	15.8349	16.6251	14.5873
010149	18.6333	18.0156	19.0199	18.5806
010150	17.8951	18.9359	19.4819	18.7907
010152	17.8306	18.7677	19.8695	18.8444
010155	9.0300	15.0689	13.6136	11.6435
010157	*	*	18.0689	18.0689
010158	17.3227	18.3957	18.8358	18.2136
010159	*	*	20.4419	20.4419
020001	28.1747	28.0394	28.6292	28.2864
020002	24.5815	25.1987	28.2759	25.9928
020004	30.5667	25.4679	26.5088	27.6844
020005	30.2920	29.2378	35.0860	31.4575
020006	31.2404	28.1417	33.0843	30.7594
020007	27.8319	32.3852	27.7269	28.9902
020008	29.4146	30.8691	31.8715	30.7301
020009	20.1930	18.4660	18.5594	19.0476
020010	23.6727	22.7559	23.7275	23.3859
020011	30.4727	28.0658	27.5062	28.6155
020012	24.8543	25.5320	26.7586	25.6982
020013	23.8847	28.1557	29.5646	26.9336
020014	27.3823	24.5875	*	25.9860
020017	26.8319	28.0572	28.8752	27.9519
020024	24.0872	25.3205	25.5933	25.0276
020025	21.7557	20.2583	29.4375	23.2312
030001	20.3673	21.7869	22.8996	21.6709
030002	21.5977	21.8375	23.1450	22.2070
030003	23.4833	22.6804	23.9849	23.3723
030004	14.0711	15.5478	13.8452	14.3965
030006	18.2668	20.0273	20.5019	19.5831
030007	19.6708	21.5169	22.2473	21.1843
030008	22.2758	22.2190	*	22.2524
030009	18.1794	18.7557	19.1258	18.6629
030010	19.0907	19.5123	19.8496	19.4665
030011	19.2973	19.4310	19.8141	19.5088
030012	18.9918	20.6585	21.1099	20.2847
030013	20.7458	20.0535	19.9517	20.2223
030014	19.9315	19.7966	20.0568	19.9241
030016	19.3967	19.4785	22.2526	20.4395

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
030017	22.8765	21.7938	23.1702	22.6064
030018	20.2032	20.8980	21.8067	20.9825
030019	21.7005	21.2540	22.0341	21.6682
030022	19.2966	19.5794	22.3351	20.3379
030023	23.6697	24.1678	25.4626	24.5066
030024	22.2541	23.6009	23.5218	23.1550
030025	12.7254	11.9894	20.2690	14.6291
030027	15.7554	17.6555	18.5500	17.3221
030030	20.8303	21.6932	23.1280	21.8856
030033	20.0044	20.2820	20.3034	20.1983
030034	16.8241	20.8689	19.5578	19.0205
030035	19.2781	20.0226	20.5339	19.9127
030036	20.7567	21.6371	22.2690	21.5890
030037	22.8266	23.7615	23.7325	23.4266
030038	22.6776	22.9822	23.4477	23.0337
030040	18.5456	19.7636	19.3706	19.2127
030041	15.8921	18.8717	18.4750	17.5529
030043	20.9341	20.5598	18.7843	19.9580
030044	16.8649	17.6575	18.6781	17.7554
030047	22.6401	21.4412	22.7385	22.2630
030049	19.0881	19.3580	19.7315	19.3525
030054	15.3338	15.0657	15.7973	15.4130
030055	16.3613	20.2991	20.8373	19.1429
030059	24.0465	22.6279	27.3929	24.5505
030060	19.2461	18.6313	19.5021	19.1145
030061	18.9063	19.9047	21.1013	19.9959
030062	17.6738	18.7172	19.2670	18.6035
030064	19.5673	20.3837	21.6435	20.5204
030065	20.5130	20.7838	22.2846	21.2496
030067	14.4446	17.2778	17.6414	16.3935
030068	17.3614	17.7208	18.9718	18.0528
030069	19.0961	21.0936	23.4902	21.1503
030080	20.5144	20.6581	21.2079	20.8105
030083	23.3355	23.5229	23.2965	23.3842
030085	21.0954	20.8690	21.4417	21.1505
030086	19.5436	*	*	19.5436
030087	21.4084	21.9465	23.1339	22.1276
030088	19.8682	20.5340	21.4201	20.6453
030089	20.4019	20.9516	22.0850	21.2122
030092	20.6986	21.8308	19.4627	20.4899
030093	19.7262	20.4314	21.7195	20.6797
030094	21.6218	22.8123	21.8049	22.0984
030095	13.7293	13.7664	20.5222	15.2252
030099	16.1541	18.2263	19.8092	18.2768
030100	*	23.7609	23.5868	23.6643
030101	*	19.2547	21.1029	20.2450
030102	*	18.2413	21.5405	19.8425
030103	*	*	15.0859	15.0859
030104	*	*	32.8668	32.8668
040001	15.1624	16.9178	16.3882	16.1463
040002	13.0592	15.1107	16.1353	14.6990
040003	14.2089	15.5740	15.5186	15.0890
040004	17.8476	17.9034	19.0105	18.2433
040005	13.2597	11.1318	16.5465	13.4890
040007	21.9583	18.6998	*	20.1466
040008	15.3040	14.7985	20.2121	16.6104
040010	18.6023	19.4913	19.8251	19.3459
040011	14.5319	16.0995	17.1337	15.8295
040014	17.6340	18.1434	19.3996	18.3693
040015	16.5891	15.5207	17.4003	16.5312
040016	19.0295	20.2321	19.8087	19.7068
040017	13.5098	15.4736	16.5602	15.1870
040018	17.6027	18.7463	18.8203	18.3807

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
040019	22.6769	23.4163	21.0465	22.2688
040020	16.4827	18.9844	17.6056	17.6157
040021	17.6398	19.6835	21.3321	19.4636
040022	17.0397	20.8281	19.2393	18.9742
040024	14.4541	17.6607	15.0590	15.6850
040025	11.5079	13.4705	14.8071	13.1413
040026	19.5563	19.7924	21.0143	20.1201
040027	16.0975	17.4431	17.7161	17.1113
040028	14.6584	13.9946	15.2850	14.6612
040029	17.8787	21.1370	22.5094	20.5216
040030	13.5428	11.2402	16.5488	13.3388
040032	13.7030	13.2872	13.8013	13.5932
040035	12.8300	10.9569	11.0611	11.5521
040036	18.9757	20.2012	21.1066	20.1370
040037	14.6559	14.0941	15.4984	14.7015
040039	14.3576	14.7177	14.8433	14.6458
040040	18.0895	19.1984	19.6704	18.9937
040041	15.9896	16.4624	17.7783	16.7177
040042	15.2142	15.2057	16.6875	15.6976
040044	12.6275	13.3501	17.1869	14.3743
040045	14.9429	16.2469	16.6648	15.9379
040047	16.8654	17.5336	18.6295	17.6726
040050	13.3818	14.0036	14.2087	13.8730
040051	15.8627	16.6039	18.0487	16.8084
040053	16.3610	15.0219	14.1508	15.1659
040054	15.3219	14.2577	16.5217	15.3669
040055	17.1269	18.0414	16.6283	17.2760
040058	17.6766	16.4278	19.3124	17.6534
040060	12.8148	17.9805	15.4220	15.0376
040062	18.2048	17.8902	19.4255	18.5267
040064	10.7255	11.5029	13.3479	11.7813
040066	18.3377	19.7144	18.7831	18.9326
040067	14.6014	14.4741	15.0081	14.6924
040069	17.5052	17.0026	18.9754	17.8560
040070	16.9027	16.9700	18.6066	17.5468
040071	16.9610	17.6144	18.0874	17.5370
040072	16.0895	17.4960	21.3094	18.1882
040074	18.3224	18.7542	20.8465	19.2921
040075	13.3623	14.0975	14.6681	14.0257
040076	19.0732	20.5840	21.8010	20.4612
040077	12.9211	13.9114	14.7230	13.8164
040078	18.7600	18.5821	*	18.6754
040080	19.2461	19.3707	22.8153	20.3838
040081	11.3169	11.1332	12.4796	11.6373
040082	16.2152	15.1331	16.4840	15.9329
040084	17.2613	17.7295	18.3410	17.7584
040085	16.8957	16.5216	14.1782	15.7843
040088	17.9636	17.1624	18.2831	17.7943
040090	17.8282	19.0824	16.6619	17.8476
040091	19.8700	20.1378	20.2904	20.1018
040093	12.3537	13.9741	14.7132	13.5635
040100	14.7587	15.6833	16.9558	15.9133
040105	15.3319	14.3896	14.8936	14.8814
040106	15.6545	18.1341	19.0936	17.8001
040107	18.8120	17.8628	20.6852	19.1446
040109	14.6266	16.6278	16.2496	15.8538
040114	18.8743	21.1231	21.3826	20.4184
040116	20.2716	*	*	20.2716
040118	19.3720	18.2123	19.6248	19.0444
040119	15.5338	16.9407	18.5876	17.0324
040124	19.1349	19.2889	*	19.2100
040126	12.5368	11.6517	16.3391	13.4177
040132	17.5179	10.3875	*	13.5846

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
040134	18.0787	19.0185	22.1291	19.8434
040135	22.6761	23.0084	*	22.8797
040136	*	*	21.4139	21.4139
050002	37.8295	36.9630	30.2629	34.5243
050006	19.5594	18.2061	22.4890	20.0298
050007	30.7126	30.8676	31.6270	31.0595
050008	26.2458	26.3682	28.2021	26.8667
050009	26.8159	28.4734	28.3021	27.8816
050013	23.2201	28.0569	27.2552	25.9477
050014	22.8478	23.6745	25.1664	23.9039
050015	26.2481	27.7731	28.2204	27.4404
050016	20.5566	21.2045	22.7014	21.5040
050017	23.9625	25.6178	25.7403	25.1023
050018	15.4721	15.2903	16.4211	15.7749
050021	25.8966	*	*	25.8966
050022	24.0318	24.5254	26.2574	24.9836
050024	21.3989	22.4274	21.5230	21.7688
050025	23.3896	24.8245	26.0161	24.7262
050026	27.8736	23.1904	23.4651	24.6800
050028	16.4671	17.6138	17.9421	17.3234
050029	25.1259	24.6839	26.6783	25.4673
050030	20.9812	21.5621	21.8639	21.4881
050032	25.2010	24.3598	24.4176	24.6502
050033	24.9328	32.0179	31.1768	29.1633
050036	21.2420	21.8239	24.1361	22.4423
050038	28.6528	29.9698	32.1757	30.1303
050039	22.7117	22.8288	23.8122	23.1279
050040	32.1287	30.2607	30.1153	30.8697
050042	24.8067	24.5260	25.4903	24.9502
050043	32.9958	33.8255	38.8988	35.0749
050045	19.8831	21.1474	21.0356	20.7131
050046	25.3185	25.2005	25.3067	25.2745
050047	29.9255	29.9580	31.6959	30.5375
050051	17.8945	18.7809	17.9266	18.1624
050054	20.7212	22.0982	19.2395	20.6257
050055	29.3984	29.2730	32.0923	30.2190
050056	27.4321	23.8396	24.7994	25.2478
050057	21.1554	20.7420	21.7403	21.2220
050058	23.1641	23.3009	24.8366	23.7800
050060	20.7747	20.5450	21.9971	21.2660
050061	23.5454	24.5488	23.9906	24.0316
050063	24.8851	25.7593	25.5798	25.3924
050065	24.0420	24.6290	27.6677	25.3130
050066	16.5725	16.1649	26.3920	18.5257
050067	23.1966	25.8857	22.1250	23.5170
050068	20.6851	19.3615	19.2325	19.8460
050069	25.9420	24.6153	25.8560	25.4593
050070	32.5166	34.0721	36.4136	34.4086
050071	33.1850	34.4367	36.4834	34.7318
050072	33.2858	39.7321	36.1146	36.2550
050073	33.3922	32.8555	36.1054	34.1118
050075	33.9095	33.7160	37.8104	35.1272
050076	27.7797	33.9752	37.0415	32.6495
050077	24.1019	24.1404	25.3481	24.5518
050078	23.0736	24.3150	22.6776	23.3158
050079	33.2432	30.0167	36.5455	33.0896
050082	22.1009	23.7617	23.7718	23.2042
050084	23.5866	25.4517	25.1155	24.6796
050088	20.8406	24.9641	25.2282	23.4877
050089	20.9117	22.8450	23.4120	22.3589
050090	23.4097	24.6070	25.4545	24.4799
050091	25.2792	23.7713	*	24.5189
050092	16.7969	17.1211	17.1883	17.0299

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050093	25.2130	25.6647	27.1820	26.0418
050095	33.6718	30.4847	29.2226	31.0314
050096	20.0487	22.7394	22.5034	21.6293
050097	16.7054	22.5991	24.2548	20.5747
050099	24.8091	25.3722	26.2363	25.4947
050100	29.8758	25.2031	23.9877	26.2195
050101	31.0264	31.8957	32.7594	31.9069
050102	22.2937	24.0014	22.6741	22.9916
050103	24.7932	25.4133	23.5946	24.5653
050104	25.5797	26.9726	25.4575	26.0072
050107	21.2690	22.2019	22.2746	21.9397
050108	23.5564	25.1758	25.6983	24.8127
050110	20.1870	19.9589	21.3399	20.4921
050111	21.5487	20.7897	21.0813	21.1480
050112	25.3015	26.8182	28.3676	26.8364
050113	28.8420	28.5224	32.3967	30.0407
050114	24.7286	26.6757	27.6486	26.3583
050115	21.3291	23.0182	24.3748	22.9340
050116	25.2130	24.9196	27.0331	25.6442
050117	23.3612	22.2123	23.0697	22.8657
050118	23.7698	23.7129	24.9094	24.1342
050121	19.5252	18.7272	18.8430	19.0230
050122	26.3172	26.9546	26.9193	26.7318
050124	22.7736	24.5069	23.9379	23.7017
050125	29.6147	32.0230	33.3290	31.6254
050126	23.9247	24.6752	26.9718	25.2082
050127	22.1937	20.9027	20.5928	21.0815
050128	25.7240	26.6132	26.2519	26.1998
050129	26.5030	24.0108	23.2118	24.4255
050131	31.0732	32.5462	33.0980	32.2202
050132	24.0834	24.0173	24.1583	24.0881
050133	24.9746	23.2093	23.9479	23.9946
050135	23.2361	24.7157	23.2750	23.7026
050136	24.7921	24.7280	28.0754	25.7753
050137	32.6507	32.9192	33.7489	33.1070
050138	37.3286	38.1584	40.8912	38.7884
050139	32.9351	31.4984	35.1492	33.0424
050140	34.1499	32.7609	36.7096	34.4570
050144	27.8751	27.4069	*	27.6480
050145	32.3857	34.5185	37.5003	34.7881
050148	21.9211	20.0971	21.1622	21.0247
050149	24.6078	26.8674	25.8880	25.7652
050150	24.9073	24.6596	25.9494	25.1761
050152	34.0766	33.3305	33.1217	33.4979
050153	30.5714	32.3389	32.1256	31.7026
050155	21.0257	25.3354	23.2118	23.0854
050158	27.5623	28.6071	28.9764	28.3557
050159	23.2912	22.5313	26.6139	23.7086
050167	21.9128	21.8796	21.9596	21.9174
050168	23.3511	25.1937	27.1971	25.2088
050169	22.3888	24.8407	24.7737	23.9439
050170	23.9574	24.3654	27.9459	25.2622
050172	20.1841	19.6120	22.0400	20.6111
050173	24.5545	24.8694	*	24.7049
050174	30.2140	30.2775	31.6888	30.7398
050175	27.2806	24.7548	26.0146	25.8419
050177	21.7943	21.1396	22.5039	21.8034
050179	21.7175	23.8868	22.8941	22.7755
050180	31.8947	33.3257	34.0900	33.1860
050183	20.3638	*	*	20.3638
050186	22.4155	23.6288	25.0791	23.7560
050188	28.0918	28.2364	30.6007	29.0015
050189	22.8687	27.4071	28.3295	26.4046

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050191	20.8321	25.3516	29.2992	25.0950
050192	18.6701	14.1996	19.0400	17.0362
050193	22.6316	24.9444	25.5294	24.3542
050194	29.7371	29.5678	28.5389	29.2648
050195	35.5621	36.9068	39.1617	37.2637
050196	18.5180	18.2411	19.4304	18.7370
050197	35.7449	32.4030	34.6750	34.1639
050204	23.6105	22.7099	23.0192	23.1063
050205	23.6831	24.1691	24.1275	23.9917
050207	21.6214	22.9941	23.4210	22.6876
050211	31.6084	31.7280	33.2481	32.1766
050213	21.4806	21.4951	*	21.4880
050214	21.7335	24.0276	21.1480	22.2422
050215	29.8563	35.0459	31.6895	32.1029
050217	19.6010	20.2042	21.3026	20.3986
050219	21.7444	21.2458	21.7637	21.5978
050222	27.4809	23.3563	23.0670	24.3640
050224	23.5316	23.5101	24.8431	23.9839
050225	23.3480	21.6820	22.0981	22.3835
050226	27.7315	24.4443	26.1959	26.0496
050228	34.0711	34.2596	36.0632	34.7751
050230	27.7357	26.6291	26.7963	27.0820
050231	26.1508	26.7321	26.8977	26.6061
050232	24.3072	24.5245	25.8640	24.8981
050234	25.7035	24.6126	25.0104	25.0823
050235	25.2527	27.0922	26.0323	26.1239
050236	26.9803	25.9458	27.7406	26.8805
050238	24.2922	24.5823	25.1796	24.6748
050239	22.6625	23.2711	24.9463	23.6289
050240	26.3657	26.7620	*	26.5501
050241	26.3740	29.8345	*	27.9992
050242	31.1576	32.0829	32.9875	32.0689
050243	28.9635	26.4627	26.0256	27.1221
050245	23.8124	23.2716	27.5920	24.8781
050248	26.2015	27.6457	28.4413	27.4692
050251	21.6574	23.6360	27.9531	24.2057
050253	16.0701	16.7540	21.0399	17.6028
050254	19.3126	20.1176	22.3414	20.6227
050256	23.6887	23.4835	25.1104	24.1533
050257	15.2306	17.2596	15.6379	16.0441
050260	23.2421	27.4234	30.1623	26.5840
050261	20.0552	20.1040	19.4649	19.8596
050262	28.8785	29.5550	30.8866	29.7520
050264	32.1312	36.0331	32.8689	33.6109
050267	26.2264	26.0401	27.8393	26.6370
050270	24.0439	25.3757	26.4092	25.2781
050272	22.4247	23.0587	23.3443	22.9405
050274	20.0422	*	*	20.0422
050276	29.8624	33.3302	34.0633	32.3736
050277	20.0520	26.0822	23.6065	23.0165
050278	24.7787	23.9289	24.9699	24.5628
050279	20.8444	21.8949	22.2776	21.6332
050280	25.2149	25.6651	26.3392	25.7541
050281	19.6888	24.2251	25.2699	22.9927
050282	28.8261	25.4428	26.4698	26.9213
050283	29.7734	31.7669	32.3270	31.3481
050286	16.5708	19.4241	20.6191	18.4349
050289	34.1393	30.4750	32.2125	32.1522
050290	28.6231	29.6796	31.5000	29.9312
050291	30.2748	29.4029	30.9334	30.2109
050292	21.6243	20.8410	21.4357	21.2903
050293	22.2963	24.1875	*	23.1602
050295	21.2892	21.7883	24.5917	22.5802

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050296	27.2948	28.3906	30.0984	28.6215
050298	24.4477	23.2006	22.4000	23.3022
050299	26.4543	25.5035	24.6751	25.5099
050300	23.5116	25.9228	26.0298	25.2222
050301	22.5201	21.1403	24.7987	22.7770
050305	34.5185	36.7908	36.6981	36.0318
050307	17.2147	*	*	17.2147
050308	29.3803	28.9284	28.5759	28.9478
050309	23.7884	25.3515	25.5221	24.8819
050312	26.7617	26.0015	26.0172	26.2525
050313	21.7577	25.6827	28.9126	25.5297
050315	24.7086	22.7359	25.8372	24.4689
050317	21.6937	*	*	21.6937
050320	30.4101	32.4809	31.6571	31.4911
050324	26.6049	25.3694	26.8313	26.2820
050325	24.4862	23.6327	22.6353	23.5919
050327	23.9484	25.6450	*	24.7970
050329	19.7455	21.6984	24.2134	21.8073
050331	22.2536	25.0230	25.2110	24.0855
050333	19.4589	19.1449	14.1808	17.2305
050334	34.2330	34.2557	34.3956	34.2968
050335	23.0258	22.9926	22.9335	22.9822
050336	20.7979	21.3402	18.9187	20.3375
050342	20.1841	20.8255	22.4356	21.1404
050343	17.2085	*	*	17.2085
050348	23.8779	25.1085	29.3364	26.0263
050349	14.9754	15.0667	15.4536	15.1663
050350	24.8340	26.4161	27.2368	26.1456
050351	25.4791	24.8121	25.2436	25.1768
050352	26.1380	26.4262	27.7489	26.7934
050353	23.0564	23.2699	24.1009	23.4992
050355	17.2778	21.0969	*	18.6280
050357	22.6545	24.5345	24.3540	23.9188
050359	17.7907	21.7548	19.6236	19.5994
050360	31.3526	31.7583	33.3592	32.1693
050366	23.7528	19.6823	22.0442	21.7233
050367	28.2805	30.7328	31.7487	30.2799
050369	27.0548	26.2234	26.6627	26.6233
050373	26.9776	27.8275	29.9749	28.1900
050376	26.5840	28.0990	28.4026	27.6603
050377	17.1764	17.0012	*	17.1127
050378	25.9810	26.9101	27.8389	26.9067
050379	15.2022	18.4278	*	16.6705
050380	31.4343	31.9578	31.5137	31.6362
050382	26.1398	25.9244	26.3968	26.1598
050385	24.6083	*	27.1692	25.6464
050388	19.1512	22.0122	17.6762	19.5684
050390	25.0426	24.2700	25.8556	25.0345
050391	18.9266	20.0615	19.0832	19.3414
050392	21.6729	22.9430	24.9003	23.1073
050393	25.6964	24.1981	25.4028	25.0965
050394	23.0604	23.1526	23.1641	23.1275
050396	24.0636	25.3729	25.7580	25.0612
050397	20.2601	20.6397	23.3212	21.1533
050401	20.7473	18.4593	*	19.5658
050404	17.3396	15.9839	16.4845	16.6030
050406	17.3016	17.8596	21.5282	18.7226
050407	29.9642	30.8346	32.0753	30.9310
050410	17.6769	19.8508	17.1718	18.1805
050411	34.8899	33.1943	33.1718	33.7076
050414	24.2060	25.9723	24.4936	24.8800
050417	21.5739	23.3005	23.3862	22.7800
050419	23.7584	23.4936	25.1449	24.1188

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050420	22.3166	23.5438	26.4201	24.1207
050423	17.3771	21.3552	24.8113	20.9574
050424	22.8350	24.0727	25.9378	24.3139
050425	32.8364	35.3712	33.7276	33.9997
050426	25.2453	29.0120	27.4428	27.1541
050427	20.1674	16.4330	*	17.9553
050430	23.8788	21.2275	25.2322	23.4217
050432	24.4133	24.5630	26.0686	25.0170
050433	17.4643	18.9021	17.7980	18.0325
050434	19.7591	*	24.0017	21.7788
050435	25.6676	23.3426	22.2458	23.7166
050436	14.8121	*	*	14.8121
050438	25.0138	23.2583	25.3763	24.5467
050440	23.5167	22.5400	25.4767	23.8254
050441	28.9804	31.8774	33.4696	31.2892
050443	19.9020	17.2875	16.8897	17.9266
050444	21.4533	22.4530	22.6469	22.1781
050446	20.4908	22.3422	20.3611	21.0344
050447	17.9751	18.9851	24.4339	20.7186
050448	19.7046	21.7718	22.6612	21.3755
050449	23.8001	23.4614	*	23.6286
050454	28.7432	30.0792	30.3063	29.7856
050455	20.1643	19.8577	20.5575	20.1952
050456	20.1254	18.1585	17.5846	18.4965
050457	34.4949	32.1910	33.5750	33.4045
050464	25.3292	25.7710	25.8092	25.6421
050468	23.3050	22.2926	22.9771	22.8607
050469	23.8759	24.5205	*	24.1896
050470	16.0292	16.0805	15.7765	15.9567
050471	25.6172	27.1597	29.4705	27.3360
050476	22.4754	24.0253	25.9458	24.2592
050477	27.9595	27.5819	30.8781	28.6932
050478	24.5401	26.3306	28.1829	26.3141
050481	28.9722	27.7973	28.5320	28.4396
050482	18.1217	16.0114	21.6091	18.2297
050483	22.7182	*	*	22.7182
050485	24.1983	24.6906	23.9507	24.2714
050488	34.6939	31.7481	33.8291	33.4344
050491	26.8703	27.4600	27.7412	27.3548
050492	19.5457	20.5030	23.4977	21.2468
050494	29.2621	29.1296	30.2875	29.5621
050496	32.5168	34.9704	32.7474	33.3456
050497	13.8110	15.4115	*	14.5264
050498	24.9677	26.1716	27.6099	26.2387
050502	22.3788	25.3701	27.2724	24.9510
050503	24.4069	23.3745	25.7668	24.5458
050506	25.0845	25.0333	27.1555	25.7636
050510	33.3774	33.7481	36.2548	34.4910
050512	35.3581	34.4368	36.0785	35.2923
050515	35.3419	33.7321	37.3440	35.4231
050516	24.7992	26.1969	25.1778	25.3919
050517	20.9550	22.0985	23.6067	22.1150
050522	35.3784	36.2127	37.0295	36.1638
050523	27.0544	31.2522	32.1272	30.1439
050526	23.8099	26.4014	27.9306	26.0042
050528	19.0611	18.9155	21.1741	19.7510
050531	22.7308	21.3948	*	22.0804
050534	24.0700	24.0001	24.4038	24.1576
050535	25.4215	26.8511	27.7626	26.6201
050537	22.2256	24.0354	26.2342	24.2063
050539	20.7129	23.3846	23.6244	22.6500
050541	34.4573	36.6149	37.0551	36.1147
050542	16.0892	17.7737	21.8129	18.4625

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050543	22.3994	21.6795	22.4134	22.1708
050545	26.3304	31.7280	33.6302	29.6054
050546	26.1949	38.8087	39.4266	31.5013
050547	26.8305	37.7681	37.7633	31.6990
050548	28.8083	29.8516	30.3336	29.5564
050549	27.2765	28.9615	30.0948	28.8364
050550	24.8048	25.6588	*	25.2235
050551	25.4652	24.8084	25.9619	25.4069
050552	21.5216	20.3239	20.6068	20.8970
050557	21.1243	22.2562	23.8340	22.4197
050559	23.5759	24.7866	26.3799	24.8811
050561	34.5791	33.4423	34.2065	34.0632
050564	23.5922	24.2091	*	23.9025
050565	23.7829	20.8349	*	22.1110
050566	17.4423	22.3448	21.7712	20.6000
050567	24.6454	25.0787	26.2588	25.3566
050568	19.5816	20.5376	21.9313	20.7038
050569	26.5479	27.3429	27.3294	27.0680
050570	25.2294	25.8619	26.8965	26.0357
050571	26.2039	24.0154	24.6237	24.9296
050573	24.9644	25.6589	25.9380	25.5333
050575	19.5611	20.7090	27.8579	22.3375
050577	25.1549	23.5487	25.2861	24.6231
050578	28.5379	28.9009	32.0554	29.7756
050579	30.4952	29.9348	32.0245	30.8151
050580	25.9004	24.6962	22.7522	24.4365
050581	23.8584	24.9807	26.0580	24.9311
050583	24.3987	25.8800	26.2664	25.5050
050584	21.2366	19.5805	24.5294	21.6929
050585	25.9426	24.2824	26.4446	25.5528
050586	23.4079	23.1850	*	23.3000
050588	25.3094	24.5472	27.0506	25.7065
050589	24.8698	23.8880	23.7918	24.1317
050590	22.4480	24.4797	25.7756	24.1986
050591	23.9412	25.0209	26.7662	25.1993
050592	21.1745	22.1174	23.8267	22.4222
050594	27.1584	27.7002	28.7415	27.8366
050597	22.8523	23.3280	23.1209	23.0979
050598	24.3597	23.9202	25.1622	24.5206
050599	29.1221	26.0892	26.3782	27.1542
050601	31.8670	29.7417	29.7734	30.4482
050603	23.3390	21.7031	24.9032	23.2638
050604	34.0461	35.4034	36.4669	35.3805
050608	18.0947	18.1664	20.7987	18.9517
050609	34.9935	33.5028	34.8949	34.4263
050613	23.3835	30.2413	34.9980	28.8691
050615	23.8815	27.5682	25.8698	25.6901
050616	22.7437	24.9843	25.0016	24.2299
050618	21.6509	21.4895	22.3548	21.8584
050623	29.1806	27.5832	28.6475	28.4545
050624	22.7148	26.4659	22.4030	23.6850
050625	26.4849	27.5816	28.1438	27.4404
050630	23.9159	24.2120	25.1453	24.4580
050633	23.1918	25.4283	27.8165	25.4720
050636	21.2618	23.5257	25.0214	23.2191
050638	18.2859	18.2159	15.6375	17.1599
050641	21.8315	17.1258	17.9379	18.6266
050644	22.3456	22.1489	*	22.2474
050661	19.6780	*	*	19.6780
050662	26.9606	35.0989	38.9592	31.5421
050663	30.6591	24.9110	22.7770	25.2271
050667	24.9979	27.5045	26.9236	26.1684
050668	42.0974	61.7751	57.8627	51.0207

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
050670	20.0152	24.6101	24.1626	22.6855
050674	34.7380	32.4807	33.7845	33.5929
050675	15.6794	*	*	15.6794
050676	18.6672	20.2087	16.3948	18.3663
050677	35.6503	33.6070	34.0936	34.4139
050678	26.8741	22.7756	25.2143	24.8560
050680	28.0584	31.4839	31.9166	30.4823
050682	26.2882	17.3566	19.8107	20.5443
050684	22.3398	23.3697	24.2792	23.3071
050685	31.1725	35.1307	30.4194	32.1391
050686	35.2631	33.4420	34.8278	34.4753
050688	30.6635	31.0648	34.9936	32.8691
050689	30.7295	30.9399	34.0571	31.9763
050690	32.8204	34.8112	36.7516	34.8707
050693	26.8265	25.5662	29.1213	27.1699
050694	23.2293	23.5572	25.1964	23.9614
050695	21.1377	24.4301	26.2838	24.0169
050696	28.0015	28.3291	29.6685	28.6563
050697	21.1566	18.2338	24.1116	21.0055
050698	*	*	24.9559	24.9559
050699	25.7843	17.5296	23.4611	21.9391
050701	22.6959	24.3055	26.4901	24.3588
050704	22.8716	22.7618	25.6565	23.8031
050707	26.2732	27.8958	28.2637	27.6356
050708	22.7821	24.8647	24.5606	24.0910
050709	21.9598	19.4977	21.8770	21.0737
050710	26.9060	27.5828	30.5918	28.4895
050713	17.7259	16.8538	18.2822	17.6031
050714	28.9314	30.1925	30.3290	29.7818
050717	25.9534	28.7973	31.5021	28.6924
050718	17.6062	18.0940	22.5989	19.6750
050719	25.5508	23.0833	*	23.8495
050720	*	25.8677	*	25.8677
050723	*	*	32.0291	32.0291
060001	21.3659	21.1819	20.6781	21.0801
060003	19.8023	20.4682	21.9043	20.7102
060004	22.8750	21.4496	22.9265	22.4496
060006	19.3651	20.0213	21.0003	20.1579
060007	17.4682	18.2977	19.3071	18.3452
060008	18.0333	18.4590	18.7097	18.3997
060009	21.4312	22.7164	23.9272	22.7121
060010	24.0872	23.6827	24.7332	24.1778
060011	23.4366	22.3458	22.2058	22.6927
060012	20.1442	19.4932	21.2980	20.3114
060013	22.7346	19.1256	23.5248	21.7755
060014	24.2459	24.3210	25.7689	24.7914
060015	20.9773	23.2469	23.6015	22.5801
060016	16.4707	20.2408	20.2361	18.8056
060018	20.3183	21.5083	21.8478	21.1863
060020	18.3099	18.8985	19.4966	18.9093
060022	21.0558	21.0830	22.6052	21.6192
060023	19.2373	21.5475	22.6480	21.1568
060024	21.9955	22.9185	23.5154	22.8418
060027	20.9846	22.0713	21.7571	21.6190
060028	23.2065	23.1792	24.2985	23.5665
060029	20.8585	18.2938	19.8498	19.6763
060030	20.5002	20.3452	18.0264	19.6163
060031	21.1649	22.5067	23.3995	22.3074
060032	23.4162	22.8123	24.2216	23.4772
060033	15.9085	16.0760	17.8514	16.5805
060034	22.4791	23.2816	23.4859	23.0898
060036	15.0698	18.5988	18.6521	17.3368
060037	15.5611	15.4513	15.7495	15.5902

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
060038	14.0791	14.3249	16.6525	15.2260
060041	14.8934	19.1263	19.0282	17.3424
060042	19.1892	20.8597	19.3967	19.6496
060043	13.6717	13.4443	15.4073	14.1048
060044	19.7039	20.8673	21.3102	20.6215
060046	19.4567	22.2699	22.6819	21.4974
060047	15.8770	17.1534	17.9173	16.9143
060049	21.7797	23.0613	25.9592	23.6523
060050	18.2238	19.0832	*	18.6522
060052	13.4210	14.8729	16.0543	14.6462
060053	15.9806	18.0232	19.4746	17.7396
060054	22.8985	20.4160	19.7753	20.9273
060056	18.2831	18.1263	21.9586	19.5606
060057	26.4046	25.4185	24.6599	25.4808
060058	15.4856	13.8539	16.4504	15.2822
060060	15.6469	15.6018	19.4418	16.7387
060062	17.2991	16.8640	17.1032	17.1033
060064	21.2207	22.7797	*	22.0259
060065	21.6305	24.5572	23.7809	23.3223
060066	16.3485	17.2537	17.5556	16.9855
060070	17.3184	18.8960	19.2220	18.4993
060071	17.5987	17.4068	17.6452	17.5489
060073	15.7860	17.0846	18.4971	17.0767
060075	24.1550	23.8724	25.0552	24.3665
060076	24.8732	20.3265	22.9203	22.6621
060085	13.6277	14.3409	10.9724	12.8943
060088	25.2786	13.7174	18.1570	17.7609
060090	22.2974	16.3760	16.5321	18.2600
060096	21.9623	20.8937	21.9951	21.6204
060100	23.5986	23.9305	24.1341	23.8807
060103	24.8151	23.5083	24.4962	24.2301
060104	22.2295	21.1820	24.4248	22.5603
060107	14.2698	21.9221	*	16.3130
060108	*	*	19.1327	19.1327
060109	*	*	27.3180	27.3180
070001	26.0878	26.3596	27.7441	26.7515
070002	26.2801	26.1768	26.6881	26.3761
070003	25.6949	27.5200	28.1721	27.1059
070004	22.4871	24.2567	25.4310	24.0188
070005	26.6483	26.9151	27.6733	27.0706
070006	27.5674	28.6413	33.6291	30.1330
070007	26.9505	26.3313	28.0875	27.1381
070008	23.0227	24.2971	25.1362	24.0979
070009	24.6201	24.1871	24.9408	24.5838
070010	26.2354	29.2194	28.3168	27.8716
070011	23.3638	23.0883	24.8206	23.7802
070012	23.0321	28.8067	*	25.4962
070015	23.8240	28.1204	29.2693	27.0233
070016	24.9148	24.4633	28.4833	25.9349
070017	26.2923	26.0424	27.5515	26.5441
070018	28.0689	30.6864	32.6301	30.4394
070019	25.7283	24.9249	26.2348	25.6326
070020	23.9987	25.9964	26.6203	25.5573
070021	25.2978	26.3043	29.4596	26.9916
070022	26.5691	26.9111	26.9907	26.8202
070024	25.2983	24.8948	26.2173	25.4902
070025	25.1315	25.4345	27.3592	25.9673
070027	23.6412	26.8450	25.8163	25.4005
070028	24.6788	25.7492	26.7286	25.7052
070029	22.0080	23.9682	23.8427	23.2454
070030	28.9117	22.1578	*	25.8929
070031	23.4419	24.1198	25.6347	24.3735
070033	30.4214	31.4736	32.8256	31.5451

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
070034	28.9200	29.4916	30.0480	29.4611
070035	23.0869	24.1423	24.1838	23.7950
070036	28.8400	29.9470	31.2961	29.9831
070038	*	*	26.3126	26.3126
070039	22.9032	22.3356	*	22.7640
080001	25.4836	24.8833	26.8887	25.7287
080002	19.6011	20.1965	20.9385	20.3062
080003	22.1856	23.1275	24.8200	23.2380
080004	21.9391	22.9706	21.7344	22.1849
080006	20.0792	22.6671	20.8203	21.1329
080007	19.6213	21.3746	21.1211	20.7477
090001	21.7526	21.5751	23.0365	22.1027
090002	19.4191	21.5726	20.6550	20.5048
090003	22.1090	23.1268	26.6720	23.7360
090004	24.3367	25.5054	25.9717	25.2072
090005	23.8620	26.3074	26.6217	25.5545
090006	20.8675	22.0957	22.6250	21.8452
090007	22.1973	29.2840	26.7809	26.4132
090008	20.2166	25.2708	*	22.7566
090010	24.1287	23.6616	25.9373	24.5182
090011	27.4781	26.6349	28.0948	27.4100
100001	19.5796	20.2157	21.9071	20.5375
100002	20.7136	21.0222	21.5772	21.1199
100004	14.6283	15.4149	16.1638	15.4361
100006	20.1133	21.2293	20.9190	20.7854
100007	21.7242	22.1590	22.5317	22.1527
100008	20.4980	20.8381	21.6416	21.0118
100009	22.6419	22.1741	21.3298	22.0295
100010	21.9078	23.0637	23.9582	22.9492
100012	19.6177	20.4659	21.7527	20.6367
100014	19.8023	19.5770	21.7358	20.3525
100015	18.4779	18.0654	18.9383	18.4860
100017	19.0608	19.8655	20.0861	19.6893
100018	21.0332	21.6388	22.5429	21.7594
100019	22.6152	23.5462	28.2362	24.8745
100020	21.3848	20.7816	21.7421	21.3134
100022	26.4094	26.5695	27.4235	26.7855
100023	19.9739	19.1787	20.2034	19.7906
100024	21.8791	22.1332	22.9872	22.3458
100025	18.7774	19.4529	20.1360	19.4381
100026	20.5641	20.9461	21.3742	20.9788
100027	19.1481	14.7916	20.5889	17.6926
100028	19.3757	19.3371	19.7475	19.4900
100029	20.8745	20.8950	22.2553	21.3244
100030	22.8204	20.5952	20.4996	21.1231
100032	19.8127	19.7451	20.6543	20.0503
100034	17.8743	19.5282	20.1214	19.1092
100035	20.1540	23.8117	21.2830	21.7761
100038	23.3578	24.5864	24.9548	24.3305
100039	21.5297	21.7861	23.3111	22.2259
100040	19.0449	18.6321	18.7546	18.8065
100043	18.7993	18.8206	20.7414	19.4322
100044	21.4764	22.7236	22.4824	22.2380
100045	20.9216	21.0228	22.8096	21.6136
100046	21.6207	21.3028	23.8909	22.2917
100047	20.0114	20.6068	21.4971	20.7134
100048	15.0584	15.7790	17.3663	16.1388
100049	18.8535	19.1025	20.9490	19.6376
100050	17.2377	17.9039	17.8960	17.6845
100051	23.1273	17.9453	19.3264	19.7334
100052	17.9537	18.1780	17.9957	18.0416
100053	20.1724	19.6800	21.6634	20.4905
100054	23.5491	21.1518	20.8078	21.8397

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
100055	18.0547	18.8760	19.1324	18.6804
100056	25.7863	21.8506	23.1737	23.6729
100057	19.9712	19.5319	22.3406	20.5479
100060	23.2561	23.5997	*	23.4313
100061	22.1133	22.9176	24.4704	23.1202
100062	19.4370	21.4424	21.9054	21.0072
100063	19.2629	18.4642	19.0908	18.9473
100067	18.0877	18.4851	18.5405	18.3328
100068	19.9305	19.8308	19.9648	19.9094
100069	16.8271	17.3666	18.5789	17.6344
100070	18.7408	20.0381	20.9592	19.7991
100071	17.5451	17.7234	20.7461	18.6293
100072	21.0225	20.5968	22.0317	21.2423
100073	21.1898	22.2812	22.2425	21.9197
100075	18.3688	19.4480	20.4664	19.4104
100076	17.8733	17.8612	18.4815	18.0825
100077	22.3438	19.0640	16.8641	17.3061
100078	18.4499	19.2891	14.4191	17.3311
100080	22.1966	22.7153	21.3374	22.0479
100081	14.8313	15.4253	16.5149	15.5681
100082	18.8998	*	*	18.8998
100084	22.3674	22.7009	24.5682	23.2945
100085	22.1231	*	*	22.1231
100086	21.6997	23.3718	24.3067	23.1462
100087	23.6090	23.6562	21.2831	22.8681
100088	20.3693	20.5566	20.0598	20.3349
100090	19.1479	19.7695	21.0431	20.0438
100092	17.9216	20.1760	20.5186	19.5588
100093	16.5128	16.8422	18.7153	17.3704
100098	19.2427	20.8315	21.1723	20.4066
100099	15.7823	15.7591	16.5624	16.0147
100102	18.9701	19.7673	19.0195	19.2464
100103	17.2364	18.7844	20.6957	18.8771
100105	21.6604	21.8268	22.7793	22.1049
100106	17.2527	17.4958	21.4342	18.9189
100107	20.1281	20.0719	21.7553	20.6632
100108	19.9593	20.1125	18.4127	19.5107
100109	20.8440	20.8370	20.5973	20.7560
100110	20.8995	20.1853	22.2354	21.1342
100112	25.2570	15.2128	16.2109	17.7240
100113	23.2020	21.3489	22.7264	22.3351
100114	21.6262	22.8178	22.5326	22.3196
100117	20.7624	20.6962	21.3007	20.9256
100118	22.8702	20.7323	21.4486	21.6456
100121	*	18.5842	18.8073	18.6952
100122	19.8783	19.2643	24.9765	21.2147
100124	17.0713	20.4022	*	18.7024
100125	18.9535	19.6097	20.3232	19.6414
100126	19.5413	19.3103	21.4349	20.0428
100127	19.9860	19.2122	20.4778	19.8925
100128	20.1536	22.8826	23.5835	22.0798
100129	19.1936	*	*	19.1936
100130	18.6751	20.0947	21.0023	19.9341
100131	23.4373	23.1622	24.1745	23.6099
100132	18.1167	18.7863	19.0747	18.6426
100134	15.1764	15.9733	16.9302	15.9832
100135	18.8253	19.1865	19.7675	19.2758
100137	18.6955	19.5562	20.9015	19.8112
100138	17.1373	14.9539	14.9760	15.5324
100139	15.6514	15.2532	15.7378	15.5541
100140	17.1389	19.0584	20.1703	18.8122
100142	19.6815	18.4113	17.7250	18.5714
100144	12.2877	*	*	12.2877

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
100146	18.1267	21.3359	21.9435	20.4800
100147	14.6616	15.2348	17.1566	15.6835
100150	21.2807	21.5057	25.4269	22.5635
100151	21.6087	23.8489	26.6143	24.0945
100154	20.0015	20.4068	21.6715	20.7094
100156	19.4980	18.4779	20.0348	19.3485
100157	22.6744	22.6195	24.2188	23.1792
100159	10.2793	10.7818	15.0633	11.7916
100160	20.5581	23.3121	22.6942	22.2030
100161	22.2994	22.3053	22.6534	22.4189
100162	20.1411	20.3110	20.4188	20.2955
100165	19.0388	22.6622	*	21.0526
100166	20.0250	21.2309	22.2379	21.1128
100167	23.4075	23.2969	25.6873	24.1145
100168	20.1994	20.3167	23.0121	21.2144
100169	20.9506	20.3017	21.6397	20.9720
100170	18.5088	19.3005	21.2469	19.5894
100172	14.3446	14.8826	15.7827	14.9994
100173	18.5662	17.1337	18.3828	18.0289
100174	26.1826	21.9807	*	24.0224
100175	18.1692	20.5442	21.2532	20.0936
100176	22.8604	24.3089	24.6595	23.9677
100177	24.4296	24.4284	26.4489	25.1965
100179	22.3015	23.0849	23.9633	23.1372
100180	20.2130	21.5388	22.6895	21.4521
100181	23.0800	18.9510	17.9048	19.7877
100183	24.6121	23.0654	22.2063	23.2470
100187	20.2533	20.8535	21.4988	20.8818
100189	21.3147	26.5962	27.1295	24.9742
100191	19.9879	21.0647	21.7024	20.8988
100199	21.7193	*	*	21.7193
100200	22.4579	23.8729	24.8878	23.7939
100204	20.8995	20.2193	20.8626	20.6601
100206	19.5710	20.1171	20.3436	20.0192
100208	21.2117	20.7029	20.4678	20.8077
100209	22.4577	23.3903	22.5915	22.8006
100210	21.3575	21.8545	23.0431	22.0260
100211	20.6427	20.7516	21.6367	21.0021
100212	21.1187	21.1263	*	21.1225
100213	20.6558	21.1818	21.9371	21.2709
100217	20.5909	22.7335	22.7116	21.9737
100220	21.2796	21.8246	22.3283	21.7592
100221	17.3965	21.2321	23.2263	20.3743
100223	20.6302	20.2233	21.3859	20.7713
100224	20.0251	21.8628	21.9515	21.2530
100225	20.6802	21.5059	22.4619	21.5424
100226	20.6858	21.8808	22.4084	21.7019
100228	21.3168	20.8810	23.4697	21.8662
100229	19.6908	18.2350	19.7259	19.2271
100230	20.5051	22.5650	23.4169	22.2637
100231	17.9226	18.7526	21.1128	19.1318
100232	19.3491	19.8002	19.9125	19.6887
100234	20.9104	21.6360	23.4761	21.9136
100235	17.1622	*	*	17.1622
100236	20.3766	20.6942	21.5316	20.8545
100237	22.0865	23.2408	23.2712	22.8481
100238	19.6367	20.8252	22.8488	21.0709
100239	21.3193	19.4481	23.0048	21.1692
100240	20.4340	21.0606	21.3495	20.9700
100241	14.7224	17.1063	14.1059	15.3322
100242	17.9260	18.6938	18.9062	18.5149
100243	21.2644	20.8041	22.4644	21.5426
100244	18.6227	20.5352	21.2521	20.2154

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
100246	19.6376	21.9247	23.5171	21.5681
100248	20.7007	21.2988	21.8086	21.2951
100249	19.2808	18.1397	18.4932	18.6366
100252	17.7778	19.8079	22.0976	19.8858
100253	21.3232	22.4778	22.6517	22.1811
100254	19.6598	19.5523	19.5050	19.5721
100255	25.2119	21.0284	20.7228	22.1421
100256	20.9356	21.2786	22.0528	21.4173
100258	21.3501	20.0300	22.0790	21.1494
100259	20.3815	21.1160	21.4991	21.0228
100260	21.0506	24.9183	21.1292	22.2409
100262	20.0433	21.0927	22.7137	21.2022
100264	19.1556	19.9491	21.5104	20.1857
100265	18.8301	18.2291	20.2365	19.1431
100266	18.2993	19.3623	20.2821	19.3534
100267	20.1141	21.7430	21.7446	21.2105
100268	23.9249	24.0538	23.6367	23.8643
100269	21.6724	22.5114	26.0271	23.4143
100270	15.1462	16.7148	20.8217	17.5380
100271	20.4824	20.8695	21.9823	21.1576
100275	20.9188	21.4904	23.2088	21.8580
100276	22.3646	24.1022	24.8251	23.8061
100277	16.6255	19.7241	14.9157	16.6327
100279	22.9095	22.5879	21.1094	22.2253
100280	17.3676	18.1972	19.0157	18.2076
100281	22.4392	23.0142	23.4729	23.0255
100282	19.1978	18.4884	20.9256	19.5516
100284	*	18.9448	18.4204	18.6867
110001	19.1971	20.1150	22.3072	20.5112
110002	17.1406	19.5158	20.2149	18.9927
110003	18.1168	17.1450	18.2792	17.8514
110004	19.5591	19.7733	20.6096	19.9776
110005	17.7348	22.4568	21.8105	20.9768
110006	20.7820	21.0601	21.9525	21.2769
110007	21.9505	25.2523	26.3143	24.5085
110008	22.0081	18.5265	19.9606	20.1468
110009	16.3069	17.4306	16.6452	16.8052
110010	23.3213	23.9104	25.1930	24.1454
110011	18.6144	18.9823	20.4028	19.3209
110013	16.2811	18.9160	16.7833	17.3444
110014	16.0658	18.1787	18.4463	17.4976
110015	21.2146	20.9926	21.2600	21.1563
110016	22.5321	14.2398	14.7571	16.4041
110017	13.1960	22.2537	21.2970	19.1377
110018	19.6064	22.1480	22.3933	21.3958
110020	18.3147	19.4617	20.9687	19.5535
110023	21.1994	22.0546	*	21.6186
110024	20.7297	20.7345	21.3945	20.9529
110025	19.5749	20.4232	20.2493	20.0573
110026	17.2977	16.2484	16.6320	16.7325
110027	16.0642	14.7081	19.8976	16.6619
110028	20.1547	29.1670	28.1695	25.3235
110029	20.2906	21.2150	21.3492	20.9560
110030	18.8105	19.6412	20.4656	19.6568
110031	19.9482	20.0553	20.9219	20.3082
110032	15.7349	18.2014	19.2685	17.6324
110033	22.1879	25.6335	23.1939	23.6010
110034	19.6055	19.5554	23.0724	20.6505
110035	19.3795	22.7950	21.8646	21.4160
110036	22.2498	24.9234	25.1127	24.0254
110038	17.7060	17.7396	18.4508	17.9715
110039	20.6011	20.4998	18.9817	19.9578
110040	17.0743	16.8083	17.7798	17.2164

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
110041	18.8035	20.2755	20.1398	19.7378
110042	24.0153	25.2331	25.0535	24.7832
110043	20.1016	20.6150	21.2714	20.6367
110044	16.3624	17.2087	17.5905	17.0642
110045	20.2498	21.3049	20.6934	20.7294
110046	19.7377	21.4905	22.8820	21.3991
110048	16.3148	15.6113	18.8751	16.8775
110049	16.1817	16.8639	17.1396	16.7155
110050	20.7619	19.2291	18.9048	19.6044
110051	17.0070	17.2292	17.2050	17.1503
110054	*	20.0549	20.5698	20.3256
110056	15.6202	17.7959	16.0362	16.5039
110059	16.6678	16.7990	17.8076	17.0958
110061	15.0367	16.3557	17.4601	16.2796
110062	18.8019	17.0053	17.9421	17.8940
110063	16.9612	18.5071	18.0256	17.8146
110064	18.9515	19.1203	18.8578	18.9772
110065	15.6771	16.3546	16.9829	16.3529
110066	21.0207	22.4189	23.4554	22.2503
110069	19.3109	20.9575	21.1513	20.4832
110070	21.0227	17.3438	19.6361	19.3058
110071	14.5984	18.8321	21.5042	17.7757
110072	12.7877	12.7625	13.6626	13.0734
110073	15.4261	16.4658	17.9372	16.5696
110074	21.3945	22.3769	24.4924	22.7969
110075	18.5199	20.1757	20.1604	19.6679
110076	21.2867	21.9798	23.6127	22.2999
110078	22.3718	24.0893	25.9119	24.1213
110079	21.0593	22.1070	22.3641	21.8325
110080	18.4768	19.1839	19.4635	19.0419
110082	23.8768	24.3140	22.7015	23.5986
110083	23.1219	23.1463	22.2609	22.8147
110086	18.2815	16.6374	19.0164	17.9653
110087	21.7773	22.7069	24.0994	22.9041
110089	18.5587	19.3855	19.0453	18.9917
110091	19.5114	21.5328	23.7110	21.5509
110092	17.3479	16.9725	15.9178	16.7054
110093	*	16.9827	*	16.9827
110094	14.5641	16.9503	16.8890	16.0918
110095	16.4670	17.1195	17.4302	17.0118
110096	16.8541	17.4157	18.0418	17.4444
110097	15.5811	17.4558	17.8454	16.7969
110098	16.3532	16.0597	16.7800	16.4135
110100	18.6978	19.0764	18.6822	18.8175
110101	10.8187	18.8491	13.8787	13.5799
110103	13.6842	21.1837	21.5683	17.7316
110104	15.7781	15.9431	16.6322	16.1150
110105	16.8909	16.7775	18.1306	17.2936
110107	19.3609	19.3897	21.0863	19.9482
110108	19.7938	25.2161	20.1140	21.3451
110109	15.9359	16.4031	16.5977	16.3157
110111	18.5108	18.3951	18.4274	18.4433
110112	19.0619	19.8986	18.9574	19.2821
110113	16.8179	15.9532	16.0942	16.2556
110114	14.6888	16.4812	16.8297	16.0087
110115	43.9427	22.5049	26.5759	28.7027
110118	20.5368	19.7509	17.5714	19.1118
110120	15.2589	17.7452	18.4738	17.1958
110121	16.2711	19.3643	18.8744	18.1723
110122	21.1385	21.1469	20.4922	20.9166
110124	17.5732	18.3366	19.4093	18.3953
110125	19.1311	18.0090	19.4207	18.8387
110127	14.6143	20.3765	16.1107	17.0392

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
110128	18.1845	18.0835	19.5450	18.6049
110129	18.9388	19.0001	20.8935	19.6183
110130	16.0580	14.6011	16.6915	15.7591
110132	16.0419	16.3943	17.1820	16.5355
110134	12.5723	19.8639	19.0305	17.6901
110135	17.4380	17.3504	15.6668	16.7018
110136	18.0639	16.9629	20.7827	18.4333
110140	17.8870	17.7915	*	17.8447
110141	13.2501	14.4935	13.2710	13.6692
110142	14.6144	13.9525	14.1203	14.2070
110143	20.1603	22.5926	22.4254	21.8082
110144	16.8685	17.5112	17.5678	17.2876
110146	16.1316	17.1835	17.5940	17.0117
110149	17.7535	32.1975	25.2525	24.0956
110150	20.2644	21.2909	22.4899	21.3508
110152	15.3996	15.1324	16.3837	15.6496
110153	19.2744	20.5068	20.6972	20.1497
110154	14.9636	17.3761	16.5286	16.2471
110155	15.5306	16.5146	16.4756	16.1555
110156	14.7477	16.3876	16.0759	15.7007
110161	21.7153	22.2861	24.5776	22.9656
110163	20.4202	18.6637	20.0673	19.6918
110164	20.2074	21.2160	22.5865	21.3587
110165	21.2577	20.8030	22.5604	21.5831
110166	20.5882	20.5049	22.3657	21.1057
110168	20.6646	21.8058	22.2537	21.6267
110169	20.6385	22.6648	23.3750	21.9474
110171	23.7893	25.5296	24.5313	24.5760
110172	23.3730	23.6803	24.7005	23.9332
110174	13.7339	14.6199	*	14.1346
110177	20.7187	21.2796	22.7831	21.6138
110178	18.8306	*	*	18.8306
110179	22.7841	22.0767	24.3673	23.0370
110181	14.0941	12.9798	13.9591	13.6986
110183	23.3826	22.5148	24.2899	23.3905
110184	22.1970	22.1920	22.2761	22.2235
110185	16.7246	17.7925	17.3330	17.2705
110186	17.4287	18.3178	19.7172	18.4775
110187	20.1154	19.8419	22.8248	20.9454
110188	24.8376	23.7032	21.9945	23.3633
110189	22.2715	20.8786	19.3335	20.7205
110190	18.5728	18.3649	20.7292	19.1518
110191	20.2033	21.4033	21.3404	21.0040
110192	21.4951	21.0486	22.9684	21.8761
110193	20.6380	20.7867	22.1392	21.1880
110194	15.1480	14.8115	15.8129	15.2645
110195	13.9135	12.7261	10.9444	12.3540
110198	24.1999	24.8646	24.8275	24.6410
110200	18.1862	17.7744	17.9631	17.9701
110201	20.4699	20.9497	21.9313	21.1039
110203	26.8148	22.7453	24.2062	24.5686
110204	19.7317	30.7342	35.3699	24.8432
110205	21.1435	21.3617	20.1405	20.8862
110207	12.9727	14.7154	14.6045	14.1130
110208	15.1742	15.6161	15.0350	15.2676
110209	17.9190	18.6404	20.0629	18.7585
110211	20.9372	26.9151	20.1024	22.3126
110212	11.8545	14.3790	15.8420	13.8932
110213	14.3651	*	*	14.3651
110215	20.1928	18.1539	21.0263	19.7770
110216	*	27.1878	*	27.1878
120001	27.9213	29.0427	29.4126	28.7754
120002	25.0744	25.2021	23.5667	24.5781

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
120003	25.9059	23.9115	24.6238	24.8142
120004	23.9208	24.8632	26.1398	24.8838
120005	23.3975	24.1662	22.3213	23.2601
120006	25.0895	25.8943	26.0904	25.6667
120007	22.7200	22.8772	22.7179	22.7718
120009	17.4693	16.4485	16.7630	16.8820
120010	25.1480	24.1923	24.9089	24.7414
120011	35.0582	37.2759	35.2051	35.8314
120012	23.1144	21.8507	22.0371	22.3824
120014	22.8866	24.1208	25.3557	24.0761
120015	32.9906	42.6465	*	37.0469
120016	27.9127	45.1899	43.5083	34.2774
120018	24.5031	31.1879	*	26.7466
120019	22.9341	25.5659	23.8535	24.0876
120021	23.4508	23.1839	*	23.3291
120022	21.7868	19.2614	17.3744	19.4456
120024	29.4808	32.2514	*	30.1443
120025	20.1065	50.6376	40.1332	25.3493
120026	26.0787	25.1314	25.7023	25.6323
120027	24.7255	24.4535	23.1434	24.0841
120028	27.5023	27.0897	27.5365	27.3898
130001	18.8471	17.6306	19.6328	18.7161
130002	16.6620	16.9867	18.5746	17.4270
130003	21.7313	22.3430	23.0994	22.4005
130005	20.7169	21.2386	22.6364	21.5043
130006	19.3392	20.4614	21.4640	20.4603
130007	20.8338	21.8107	22.0894	21.5806
130008	12.5506	13.6018	19.3392	14.7112
130009	19.1837	15.9701	16.8563	17.2592
130010	17.6795	17.5119	17.7826	17.6635
130011	20.5031	20.1147	22.1125	20.9248
130012	22.9813	24.9976	24.2451	24.1243
130013	17.4038	15.1129	22.6624	18.2887
130014	18.9769	19.2107	19.7560	19.3379
130015	15.7233	18.5913	16.4136	16.7965
130016	17.3942	19.0516	20.1220	18.8309
130017	17.1710	19.6875	19.9511	18.7336
130018	19.7368	19.8425	20.1934	19.9339
130019	18.6648	19.1711	19.5147	19.0953
130021	12.8588	15.6155	14.3089	14.2489
130022	16.5270	18.9127	19.7814	18.3410
130024	19.3634	19.0703	19.9934	19.4905
130025	17.5213	16.4627	17.5989	17.2009
130026	21.5934	21.8106	23.2093	22.2042
130027	21.4279	20.5344	19.0911	20.3739
130028	19.1093	20.9674	18.1205	19.2837
130029	18.4263	18.7694	22.9243	19.6491
130030	17.8440	17.5759	18.5827	17.9732
130031	16.2397	16.7766	20.4146	17.4242
130034	16.9873	18.9483	20.5802	18.9102
130035	19.3478	20.7770	16.9671	19.1314
130036	13.7933	13.6362	15.1590	14.2304
130037	18.8071	18.6856	19.2108	18.9127
130043	16.5102	16.7904	17.6920	16.9853
130044	17.8160	13.4513	16.7797	15.8094
130045	16.0990	19.0208	17.5152	17.4280
130048	16.0899	16.7900	*	16.4201
130049	20.3129	22.4440	22.0520	21.6192
130054	17.2729	17.7085	16.4675	17.1120
130056	14.6862	20.9476	28.8008	19.9051
130060	21.8662	22.7399	23.2512	22.6187
130061	15.4006	14.7394	*	15.1267
130062	16.5672	19.8157	19.8264	18.8380

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
130063	15.9441	18.8024	18.4797	18.1425
140001	16.3372	17.7990	17.7421	17.2408
140002	19.0248	19.9284	20.9959	19.9709
140003	21.2886	17.8595	18.0163	18.9220
140004	15.7042	17.4574	19.0486	17.4249
140005	11.6127	12.3002	12.4144	12.1009
140007	22.9799	23.8585	25.0105	23.9811
140008	21.6548	22.1111	24.2779	22.6707
140010	31.8207	28.5635	26.6836	28.8200
140011	17.8676	18.6164	18.4052	18.3022
140012	23.0653	21.4374	22.5885	22.3529
140013	18.3060	19.6722	20.3147	19.4284
140014	22.4737	21.4042	22.2944	22.0537
140015	16.6735	17.6805	20.3540	18.1726
140016	13.1278	14.4938	15.4454	14.3266
140018	22.3070	22.4132	23.4595	22.7307
140019	16.6548	16.4254	16.1180	16.3909
140024	16.8271	15.3782	16.1032	16.1040
140025	16.9462	18.5135	21.7775	18.9319
140026	16.6612	18.3220	19.7839	18.2263
140027	18.7553	19.2149	20.5980	19.5140
140029	22.8322	26.0833	28.0683	25.6669
140030	21.9475	23.1760	25.2828	23.5549
140031	19.5731	17.6067	16.9650	17.9987
140032	18.1058	19.0383	19.8033	18.9961
140033	24.1722	25.1639	22.8705	24.0049
140034	19.5278	19.8792	19.7711	19.7256
140035	15.2649	15.5040	17.4514	16.0631
140036	18.5771	19.1076	21.2366	19.6677
140037	13.0764	14.1083	14.3082	13.8255
140038	18.3035	18.4948	19.8197	18.8624
140040	19.9267	16.7450	18.0342	18.2044
140041	17.6582	18.5952	18.8042	18.3411
140042	15.4095	15.8892	16.1157	15.8051
140043	19.4683	20.1176	21.7356	20.4389
140045	15.5807	17.7799	17.4261	16.8835
140046	18.9763	18.6371	20.0859	19.2505
140047	17.1539	13.3610	16.6672	15.5612
140048	24.0913	23.9545	22.5870	23.5490
140049	28.4958	26.9483	27.0250	27.5281
140051	23.8264	24.0796	24.6964	24.2137
140052	19.6409	17.9571	21.0450	19.4727
140053	19.1892	19.9620	20.5244	19.8722
140054	22.1921	23.1576	23.9416	23.0858
140055	16.3404	14.3603	15.8756	15.4931
140058	17.4927	18.6861	19.1199	18.4367
140059	15.0195	*	18.2593	16.6820
140061	17.3012	18.2039	18.4264	17.9767
140062	28.0877	28.5304	28.6390	28.4255
140063	25.3641	29.1453	25.8203	26.5945
140064	19.1023	18.9379	19.6954	19.2477
140065	24.1128	25.3336	25.5939	25.0012
140066	17.3902	13.6491	15.4818	15.3710
140067	19.3267	19.5292	20.7511	19.8509
140068	19.9691	21.6188	21.6089	21.0342
140069	16.7544	17.3879	17.7785	17.3221
140070	22.9678	22.7153	25.2646	23.5870
140074	19.3504	21.6052	22.2604	20.9581
140075	21.6313	21.6434	21.0968	21.4950
140077	17.5305	17.3647	17.3236	17.4081
140079	23.3020	23.6928	22.7046	23.2149
140080	21.0739	22.1968	22.0682	21.7613
140081	16.2247	16.9808	18.1746	17.0842

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
140082	23.8960	29.7262	26.5960	26.4591
140083	19.3145	21.0330	18.0664	19.5127
140084	20.9709	22.3467	22.0706	21.7924
140086	18.3803	19.1613	19.1815	18.9175
140087	16.1009	17.1147	21.4593	18.0959
140088	25.2369	25.4176	26.5258	25.7146
140089	17.6366	18.3157	19.3230	18.4019
140090	26.4325	26.9364	28.0530	26.9854
140091	20.9018	21.9322	22.9565	21.9272
140093	18.2899	20.1528	20.7564	19.6330
140094	21.4709	21.9383	22.8892	22.0901
140095	24.0549	24.2859	23.8834	24.0755
140097	17.5081	21.1719	21.8418	20.1374
140100	21.3581	23.1399	23.8226	22.7460
140101	21.5473	21.4211	23.1418	22.0459
140102	17.1500	17.5729	18.6328	17.7567
140103	19.2783	18.1303	16.2009	17.8612
140105	22.6573	22.8944	23.8258	23.1227
140107	13.7533	11.8383	11.5827	12.2495
140108	25.4742	26.9971	27.9140	26.8421
140109	15.7465	14.5498	15.9178	15.3965
140110	19.1822	19.2888	20.9631	19.8004
140112	17.6856	17.6974	18.1119	17.8311
140113	19.0592	19.5584	*	19.3069
140114	21.1639	21.0976	22.9844	21.7634
140115	21.1926	21.0433	20.7660	21.0012
140116	23.1177	23.8993	27.8888	25.1841
140117	21.5671	21.4876	22.0889	21.7249
140118	23.5952	24.3260	25.3249	24.4123
140119	29.1419	27.9145	30.6468	29.2072
140120	18.0743	17.9716	18.5685	18.2090
140121	16.0397	16.6993	16.2607	16.3273
140122	24.6470	26.1270	26.7344	25.7959
140124	27.1906	27.9813	30.2658	28.3904
140125	17.6759	16.9516	17.8190	17.4826
140127	19.8973	20.0489	20.8397	20.2623
140128	19.4955	23.1327	23.5481	22.1101
140129	18.2639	20.2868	21.6252	19.9926
140130	22.2285	23.4298	26.0464	23.9518
140132	23.5475	23.3054	23.7046	23.5171
140133	21.4090	21.4166	20.1740	21.0117
140135	17.8100	17.3985	18.2479	17.8298
140137	16.8969	18.6330	19.2594	18.2334
140138	16.7420	17.1968	14.5771	16.0861
140139	14.0619	11.0397	*	12.4249
140140	17.8243	17.6845	18.8185	18.1076
140141	17.5204	19.1097	20.2606	18.9480
140143	19.1862	19.0810	19.9885	19.4222
140144	21.3245	22.2864	24.8854	22.7447
140145	17.5471	18.1788	19.4509	18.3977
140146	21.9573	19.9704	19.4272	20.3714
140147	16.1336	18.8049	17.1013	17.2344
140148	18.6598	18.7730	19.7630	19.0696
140150	27.3378	24.7976	28.1723	26.6696
140151	21.3896	20.0310	20.8820	20.7518
140152	24.6333	25.6011	27.9615	26.0086
140155	19.9738	20.2778	23.9957	21.3787
140158	22.7639	22.7988	23.7428	23.1140
140160	17.7691	17.7921	19.8825	18.5234
140161	20.0948	20.3799	21.2045	20.5610
140162	19.6464	20.3452	21.6901	20.5431
140164	18.7806	18.6589	19.8246	19.1100
140165	14.9156	14.7223	16.3700	15.3419

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
140166	17.5496	18.3833	18.9513	18.2817
140167	17.1479	17.6525	18.8532	17.9029
140168	16.6770	17.7453	18.2896	17.5820
140170	16.1621	16.4107	17.6901	16.7412
140171	14.1637	15.0237	15.2617	14.8002
140172	23.8431	23.6262	26.2314	24.4761
140173	15.1487	16.3924	16.0030	15.8459
140174	20.5339	35.9320	21.8272	23.9333
140176	23.2866	24.5338	26.2821	24.7364
140177	18.2648	15.0827	20.3142	17.5964
140179	21.1948	21.9859	22.6795	21.9485
140180	22.4548	22.7996	22.7508	22.6646
140181	20.8709	21.9864	22.6089	21.8164
140182	22.0170	28.9515	25.1352	24.9085
140184	17.8155	17.2401	17.9169	17.6582
140185	17.6514	18.2867	18.8573	18.2635
140186	22.7890	23.5034	20.7389	22.2767
140187	17.9201	18.3331	19.4049	18.5535
140188	15.2479	16.1907	*	15.6443
140189	21.0616	20.6627	21.1515	20.9599
140190	16.3366	17.5263	16.6673	16.8245
140191	25.8835	25.2628	27.4166	26.1852
140193	15.8022	17.4057	18.5651	17.2695
140197	18.6394	19.3774	19.9406	19.3426
140199	18.3507	18.0450	18.5409	18.3150
140200	21.5220	21.7680	22.5226	21.9573
140202	22.1939	23.7955	25.2777	23.7942
140203	19.9194	21.0848	24.8870	21.9324
140205	17.4751	20.0784	*	18.5139
140206	21.3295	22.5109	23.0603	22.2974
140207	21.9779	22.3905	25.4539	23.1447
140208	25.9900	26.2527	28.0890	26.7814
140209	18.1206	20.1557	20.2433	19.4720
140210	15.6899	14.8248	15.5345	15.3479
140211	21.8891	22.6265	22.8852	22.4887
140213	27.0645	24.9892	25.6839	25.9086
140215	15.9949	15.2893	18.5502	16.5949
140217	24.8229	25.7329	25.6584	25.3935
140218	14.9459	14.9851	17.4171	15.7345
140220	17.6370	17.8450	19.3915	18.3036
140223	24.9249	24.9017	26.2168	25.3383
140224	25.8668	32.8292	24.7882	27.5872
140228	19.6988	20.1688	21.2764	20.3895
140230	18.0918	18.2983	*	18.1984
140231	23.9176	24.5019	26.0439	24.9346
140233	19.4542	21.2333	23.5331	21.4436
140234	18.9945	*	19.7266	19.3554
140236	*	12.9253	*	12.9253
140239	18.8127	20.3745	20.9926	20.0958
140240	23.6860	24.6949	25.1418	24.5193
140242	24.5428	25.2317	26.1850	25.3655
140245	13.4839	14.2481	15.1320	14.2800
140246	13.4639	11.6267	15.0650	13.2908
140250	25.0876	23.6449	25.3410	24.6985
140251	21.4385	21.9435	23.3971	22.2702
140252	25.2246	25.0220	26.0869	25.4562
140253	18.5511	19.5858	18.4567	18.8447
140258	23.2973	25.3622	24.3731	24.3357
140271	15.5079	12.0079	16.0350	14.2915
140275	20.1699	23.8171	21.8908	21.8947
140276	26.6777	25.3134	26.1713	26.0267
140280	20.2360	18.8300	20.0763	19.6936
140281	24.0192	25.2719	26.5197	25.2957

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
140285	18.1181	18.5916	15.7435	17.3779
140286	20.3735	26.1290	24.0947	23.4832
140288	25.2327	24.4331	25.8717	25.1876
140289	17.1388	18.1747	15.9356	16.9462
140290	21.1784	22.8590	26.8449	23.6369
140291	25.0911	24.9537	26.8628	25.6578
140292	20.8560	21.9950	26.8610	23.2005
140294	17.7226	17.7301	19.4218	18.2830
140300	25.3662	27.8436	28.5457	27.2635
150001	22.8109	24.0620	22.1398	22.9956
150002	19.3401	20.7651	20.7353	20.3004
150003	19.7661	20.8636	22.3835	21.0177
150004	20.3685	21.2449	22.8060	21.4609
150005	20.6260	21.6806	22.5280	21.6427
150006	20.8158	20.6523	21.8435	21.1085
150007	20.1826	20.6635	21.2811	20.6934
150008	21.4545	21.8457	22.9042	22.0745
150009	18.7073	19.0030	19.4599	19.0578
150010	21.7125	20.5570	20.8213	21.0317
150011	18.3742	18.3275	19.8823	18.8436
150012	22.4751	22.1402	21.7903	22.1209
150013	17.0352	16.9327	17.5531	17.1857
150014	22.0143	21.5168	22.8402	22.1055
150015	22.5409	21.9037	24.2370	22.8616
150017	18.7664	19.5339	20.4814	19.6077
150018	20.4947	21.0496	23.0257	21.5245
150019	16.6327	17.8585	19.8341	18.0075
150020	15.1120	16.6600	15.9405	15.8686
150021	19.5096	21.5944	23.2077	21.4598
150022	19.1555	17.9222	18.7751	18.6044
150023	18.3598	19.3412	20.3015	19.3319
150024	18.4140	19.2295	19.8368	19.1528
150025	17.7007	20.2750	*	18.8948
150026	18.8417	22.4978	21.9448	21.0269
150027	17.3284	18.0335	19.4238	18.2383
150029	23.0546	23.2454	24.8939	23.7166
150030	17.9992	19.2406	20.5272	19.2757
150031	17.2429	18.3463	18.9672	18.2134
150033	21.8768	22.6741	23.0163	22.5338
150034	22.1317	23.1533	23.3718	22.8966
150035	20.4477	21.2374	22.3779	21.3734
150036	20.8692	21.4567	22.1464	21.5046
150037	21.7109	24.4611	22.3699	22.8076
150038	21.2193	22.0572	20.3454	21.1795
150039	18.4729	19.6215	16.0227	17.8696
150042	18.1632	20.2221	17.5614	18.5653
150043	19.0120	20.1741	20.5266	19.8572
150044	18.4381	19.1309	19.8951	19.1600
150045	16.8121	18.1670	21.3723	18.7127
150046	17.6342	18.2543	19.4146	18.4518
150047	19.7441	22.0145	21.9824	21.1814
150048	19.3329	19.1648	21.1441	19.9048
150049	17.0141	18.6451	21.6309	18.9803
150050	16.8354	17.7354	18.0411	17.5369
150051	19.0130	19.7257	20.6895	19.8190
150052	15.8590	17.3750	18.7783	17.3644
150053	19.1421	18.8632	17.8949	18.6402
150054	17.3825	18.3916	19.3424	18.3843
150056	22.4087	21.5774	23.0603	22.3391
150057	16.5882	16.9736	*	16.7800
150058	20.8178	22.1409	23.0273	22.0105
150059	21.2535	22.7360	22.9822	22.3129
150060	17.0743	18.6159	19.5011	18.4069

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
150061	17.3887	19.7968	19.4014	18.8242
150062	20.5415	20.8274	21.2608	20.9059
150063	22.0925	22.6525	24.8587	23.1574
150064	18.1400	20.3865	20.6232	19.7087
150065	19.8913	21.2153	21.4572	20.8676
150066	15.3373	19.5313	19.6845	18.2239
150067	18.2926	18.8862	19.8632	19.0434
150069	21.5310	23.3969	23.5510	22.9021
150070	17.9260	18.0827	18.9332	18.3136
150071	13.4760	13.5111	16.4179	14.3733
150072	16.2054	15.0765	18.5813	16.5238
150073	22.2968	*	19.7285	21.0407
150074	20.4175	20.2305	21.3821	20.6660
150075	15.5603	16.7532	17.1709	16.4680
150076	22.9382	22.6424	23.3724	22.9988
150078	19.2718	19.9668	20.2068	19.8183
150079	17.2436	18.2051	18.3668	17.9396
150082	17.5265	17.8381	19.6881	18.3251
150084	23.2506	24.3107	24.9054	24.1870
150086	18.9735	18.3838	19.7763	19.0552
150088	18.9869	20.3366	22.3055	20.5100
150089	23.8791	22.1725	21.0399	22.2998
150090	20.7726	21.0945	21.9803	21.2765
150091	20.4053	22.4640	26.2176	22.8558
150092	16.7434	16.9179	18.2592	17.3164
150094	16.5788	17.5244	16.7680	16.9454
150095	17.1324	19.2749	22.3214	19.5343
150096	23.2764	20.8204	*	21.9551
150097	19.3802	19.7751	21.0944	20.1363
150098	15.0943	15.2829	16.4763	15.6011
150099	22.4229	*	*	22.4229
150100	18.4148	19.8066	18.7289	18.9950
150101	16.4604	20.6209	20.9635	19.3121
150102	19.7426	23.7180	20.8818	21.3162
150103	18.4781	18.7036	19.2881	18.8849
150104	17.6981	20.0765	21.3141	19.7260
150105	20.0431	22.4412	21.6975	21.3454
150106	16.1510	16.8714	18.7088	17.2750
150109	18.8077	19.9066	21.6285	20.0890
150110	18.6627	21.9336	*	20.0654
150111	18.4556	19.2355	24.0256	20.3967
150112	20.4109	20.5253	22.1939	21.0672
150113	20.3780	19.6603	20.5871	20.2207
150114	19.5183	17.9877	18.3097	18.6233
150115	17.4315	18.4844	18.1308	18.0117
150122	18.7139	17.7867	20.7540	19.0652
150123	14.1105	14.0508	16.2898	14.8865
150124	14.6245	15.9487	16.2104	15.6060
150125	20.6735	21.3311	22.0021	21.3476
150126	21.3697	20.6857	24.0000	22.0092
150127	17.1994	17.0052	17.7858	17.3321
150128	18.5100	19.5576	20.3880	19.4584
150129	24.7711	28.6211	29.9888	27.3320
150130	18.1971	18.4846	18.3852	18.3505
150132	20.1684	20.9443	21.2747	20.8045
150133	17.3966	18.4250	19.0871	18.2346
150134	19.2526	19.3632	20.2764	19.6091
150136	20.1245	21.8097	22.9091	21.6195
150145	16.6851	*	*	16.6851
150146	*	19.0204	*	19.0204
160001	18.6035	19.0085	20.1699	19.2573
160002	15.9534	16.6003	17.6600	16.7287
160003	16.0862	16.2208	17.5429	16.6099

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
160005	17.6153	17.9405	19.3348	18.3156
160007	13.2101	15.1738	14.9137	14.4341
160008	15.9742	16.6193	16.7484	16.4416
160009	16.8391	17.9886	19.0664	17.9375
160012	16.4827	16.7112	17.9236	17.0145
160013	18.3996	18.6304	20.3023	19.1017
160014	15.9086	16.7146	18.7253	17.0747
160016	19.6322	19.9747	21.6050	20.4119
160018	14.5946	15.6141	16.0793	15.4308
160020	15.4712	15.5384	15.7960	15.6015
160021	16.5049	16.7617	16.7920	16.6812
160023	15.0665	15.0099	15.3854	15.1530
160024	19.7050	19.4764	20.5622	19.9066
160026	18.8379	19.5260	20.4567	19.6047
160027	16.3477	16.9417	18.2081	17.1431
160028	19.9595	21.0000	*	20.4650
160029	20.4678	21.3457	22.2106	21.3395
160030	19.9508	19.6182	21.6899	20.4018
160031	15.2448	16.1267	16.8957	16.0812
160032	17.3202	18.3168	19.2464	18.2782
160033	18.8673	18.8859	20.1916	19.3159
160034	15.0019	16.5957	17.3644	16.3397
160035	15.2211	16.3991	17.0165	16.0816
160036	17.8849	17.4558	20.2598	18.5977
160037	19.0532	19.5045	19.5067	19.3582
160039	17.4758	17.8647	19.1998	18.1868
160040	18.1949	18.0667	19.6339	18.6033
160041	16.7850	17.4435	18.7943	17.7638
160043	15.6909	14.8564	16.7841	15.7684
160044	16.7439	17.8323	19.5552	18.0882
160045	20.1236	20.0611	21.4757	20.5590
160046	14.5655	16.2737	16.8665	15.8592
160047	18.3593	19.0787	20.4259	19.2869
160048	14.6144	15.6856	17.2709	15.7797
160049	14.5457	15.5673	15.3233	15.1526
160050	17.4912	17.7878	21.1184	18.6885
160051	14.6400	16.4261	15.8213	15.6207
160052	18.0941	21.7647	22.1933	20.7461
160054	16.1753	16.1981	16.5258	16.3024
160055	14.7600	15.1674	17.6177	15.8187
160056	16.1575	17.0172	17.9534	17.0042
160057	18.1776	19.1378	19.6802	19.0270
160058	21.1159	22.1061	23.2042	22.1074
160060	16.0436	17.2825	17.7489	16.9862
160061	17.3215	17.0938	17.2064	17.2123
160062	17.8086	17.4388	18.8163	18.0222
160063	16.8834	16.3583	17.3771	16.8779
160064	20.5496	22.2131	25.1546	22.5347
160065	16.9373	17.1043	17.0609	17.0424
160066	17.1875	17.9971	19.3202	18.1697
160067	17.8514	16.7833	17.6602	17.4022
160068	17.9892	19.0572	20.5995	19.2056
160069	19.7280	19.1640	20.4556	19.7835
160070	16.7017	18.4588	17.7855	17.6458
160072	14.9536	14.4141	15.3384	14.9054
160073	11.8261	11.4997	15.5946	12.7126
160074	19.5092	17.9513	18.4624	18.6658
160075	19.4948	18.4613	20.7842	19.5335
160076	17.9381	17.8824	19.1590	18.2977
160077	12.8826	13.6658	15.0468	13.8624
160079	17.6187	18.6333	20.5010	18.9292
160080	18.6687	19.4925	19.6680	19.2860
160081	17.0052	17.4466	19.1442	17.8781

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
160082	19.6499	19.5322	20.6425	19.9343
160083	20.6189	19.7542	21.3221	20.5512
160085	18.0063	21.2557	19.1929	19.4359
160086	17.3271	17.5308	19.0477	17.9338
160088	20.2331	22.3655	23.8098	22.1152
160089	16.9538	17.3449	18.3526	17.5556
160090	17.1090	17.9614	18.4210	17.8146
160091	12.8516	14.2573	14.8904	13.9759
160092	15.5011	17.0633	17.9251	16.7839
160093	17.7457	18.5675	19.5732	18.6194
160094	18.7653	17.6094	18.7835	18.3744
160095	15.1895	15.2722	16.4927	15.6525
160097	15.9263	16.6790	17.7860	16.8002
160098	16.3135	16.8670	16.8997	16.6946
160099	13.9053	15.0880	16.0710	15.0169
160101	18.3705	18.9788	19.6314	18.9647
160102	18.8765	20.1161	14.4837	17.6011
160103	17.0973	18.2741	19.6168	18.2567
160104	18.8301	17.4829	21.0060	19.1043
160106	16.9639	17.3474	19.4385	17.8892
160107	18.0634	18.0097	18.8936	18.3269
160108	16.0529	16.7779	17.7577	16.8631
160109	16.5593	17.9873	18.2938	17.5854
160110	19.1420	20.6215	20.9346	20.2607
160111	14.1644	14.9965	15.1104	14.7432
160112	16.8332	17.2450	19.6950	17.9037
160113	14.7097	15.4834	14.9449	15.0474
160114	16.1423	16.5006	18.0532	16.8768
160115	15.8995	16.5654	16.9991	16.4863
160116	16.9534	16.6993	18.4261	17.3468
160117	17.9410	18.7615	19.9040	18.8566
160118	17.2523	19.4472	17.1480	17.8721
160120	10.5992	15.6789	15.0577	13.1432
160122	18.9252	18.1469	18.8469	18.6451
160124	18.0908	19.1600	19.9144	19.0634
160126	17.8142	19.4903	17.6813	18.2418
160129	16.7131	17.2112	18.0113	17.3098
160130	16.0528	15.6666	16.2628	15.9955
160131	15.4898	16.0424	16.5397	16.0265
160134	13.4743	15.3012	14.6396	14.4558
160135	18.2682	18.7711	18.3973	18.4829
160138	16.8699	17.1491	18.3957	17.4264
160140	18.4007	18.5630	19.6155	18.8655
160142	16.2875	18.1467	17.2792	17.2139
160143	16.6154	17.4497	18.1287	17.4014
160145	13.9152	16.9092	17.8887	16.1391
160146	16.6024	17.7010	19.0576	17.7319
160147	17.4880	19.4041	21.6062	19.3700
160151	16.8257	17.2177	18.3398	17.4331
160152	15.6170	15.9500	17.0750	16.1956
160153	20.2316	21.2085	22.7004	21.3705
170001	17.9304	17.9218	18.3934	18.0897
170004	15.0636	16.1442	17.2262	16.1274
170006	17.2192	17.5982	19.1802	18.0107
170008	14.9124	16.8412	17.7061	16.4380
170009	20.7795	23.1349	25.0155	23.0594
170010	18.7384	19.4584	19.5990	19.2633
170012	17.8719	18.4432	20.2281	18.8642
170013	18.6454	19.4667	20.1123	19.4285
170014	17.9349	18.4931	19.3973	18.6216
170015	16.5750	17.1302	17.2443	16.9768
170016	19.2130	20.0675	20.9301	20.0460
170017	17.7958	19.5994	19.7908	19.0428

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
170018	15.2984	15.3237	14.8794	15.1619
170019	15.2094	16.9362	17.3043	16.4640
170020	17.3400	18.1325	18.9345	18.1573
170022	18.5309	19.1888	20.3269	19.3395
170023	19.1351	19.2441	19.6533	19.3514
170024	13.6803	14.3604	15.0081	14.3388
170025	17.8667	18.7182	19.1720	18.5412
170026	15.0470	14.8974	16.6547	15.5216
170027	17.3604	17.8690	18.4466	17.8805
170030	14.6530	15.9282	12.9413	14.4010
170031	13.9601	14.2151	16.4660	14.7972
170032	15.6093	16.3449	15.2207	15.7224
170033	16.4059	19.1952	21.2104	18.9788
170034	15.8202	16.9586	17.8239	16.8326
170035	18.5885	17.0945	19.8334	18.5082
170038	14.7776	13.8582	15.2505	14.6401
170039	15.8635	17.0774	18.5780	17.1811
170040	21.6440	21.0617	23.1014	21.8449
170041	11.7566	12.4488	9.9263	11.2790
170044	15.3011	17.3254	*	16.3356
170045	14.0875	25.8331	20.5454	19.8078
170049	19.9415	20.7921	21.2917	20.7035
170051	15.0889	16.4851	16.9003	16.1546
170052	15.0108	15.2283	16.0948	15.4803
170053	16.5102	14.6133	14.3628	15.2080
170054	14.4353	14.6354	15.1330	14.7339
170055	16.9800	18.2607	18.1783	17.7932
170056	17.0442	18.3550	19.7369	18.3732
170057	13.0007	*	*	13.0007
170058	18.6983	19.5415	20.1090	19.4664
170060	17.3482	18.9853	17.5290	17.8991
170061	15.6527	15.0258	15.2924	15.3392
170063	12.8082	14.1185	13.7611	13.4911
170066	15.5322	16.2891	16.8009	16.1505
170067	14.7492	14.9921	20.7945	16.7328
170068	15.1790	17.0022	19.2629	17.0101
170070	14.2445	14.0627	14.8348	14.3652
170072	12.6329	12.7709	*	12.7037
170073	17.5368	17.7056	17.7586	17.6632
170074	17.5537	17.3699	17.2800	17.4035
170075	12.4212	13.6816	14.4939	13.5832
170076	14.5866	14.6109	14.9392	14.7111
170077	13.5235	13.9104	14.1376	13.8508
170079	13.5261	11.5902	16.7227	13.6766
170080	12.6014	14.8293	13.6794	13.6471
170081	13.8077	14.6823	15.0840	14.5566
170082	12.8563	13.7462	14.8154	13.7610
170084	12.5410	13.0519	13.5927	13.0488
170085	15.4518	17.5422	21.8907	18.4877
170086	20.4068	19.7182	20.2892	20.1437
170088	13.4542	13.4860	*	13.4703
170089	18.8136	15.4860	20.2263	18.3293
170090	11.9147	10.9444	*	11.4573
170093	13.5490	14.0276	14.7803	14.0852
170094	20.1985	21.2035	21.2484	20.8944
170095	15.5463	15.3532	16.1078	15.6715
170097	16.4608	17.7540	18.6805	17.6242
170098	15.5259	16.6210	17.3480	16.4881
170099	13.6033	14.3370	16.5247	14.7568
170101	14.5629	18.0143	17.3381	16.4637
170102	13.6321	14.2447	14.4499	14.1084
170103	17.2844	17.9530	18.6172	17.9709
170104	20.6182	21.0049	21.9487	21.1996

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
170105	16.5408	16.7403	18.2788	17.1877
170106	18.5479	17.7467	*	18.0680
170109	17.2629	16.9782	18.3483	17.5682
170110	16.9823	18.5731	21.0637	18.8359
170112	14.3855	15.4049	15.8097	15.1873
170113	13.9038	14.6486	16.4938	15.0142
170114	14.4545	16.2645	13.8347	14.7519
170115	12.6997	12.9216	13.0253	12.8848
170116	16.8714	18.1830	19.4278	18.1442
170117	15.7875	16.8237	16.8301	16.4481
170119	15.1990	15.2708	15.1982	15.2222
170120	17.6748	17.4917	18.2061	17.7788
170122	20.0615	21.1769	21.4205	20.8657
170123	23.1697	23.6534	25.2071	23.9580
170124	11.1249	15.0596	16.3925	13.8286
170126	12.8096	13.5736	14.5527	13.6140
170128	14.8891	14.1676	17.6259	15.4144
170131	10.1000	*	*	10.1000
170133	18.0243	18.8119	19.9778	18.9214
170134	14.1085	14.6799	15.1932	14.6538
170137	17.8290	19.3118	19.3344	18.8395
170139	14.1967	14.3001	14.8157	14.4193
170142	*	17.7134	18.9169	18.3246
170143	15.6509	16.0415	16.3258	16.0049
170144	19.0929	20.4392	20.7583	20.0727
170145	17.1837	19.0142	18.1398	18.1031
170146	20.9075	21.7919	25.4405	22.7798
170147	22.3017	17.6717	17.4968	19.0192
170148	16.9183	19.1942	24.4828	19.5145
170150	15.5651	15.9072	14.9718	15.4692
170151	13.8934	14.3668	14.5002	14.2317
170152	14.9139	15.6423	16.0930	15.5503
170160	13.7108	14.4732	17.0629	15.0179
170164	16.6542	17.4072	17.0791	17.0445
170166	27.5567	12.7507	16.5113	18.0323
170171	12.5200	13.1792	14.7051	13.3708
170175	19.0232	20.1907	19.9712	19.7266
170176	21.3400	23.5043	23.5743	22.8029
170180	16.6921	8.6352	*	11.8552
170182	22.2164	21.3454	21.9797	21.8339
170183	20.3505	19.5182	16.6577	18.5979
170185	*	*	26.6814	26.6814
170186	*	*	32.9088	32.9088
180001	17.9906	20.4885	20.8419	19.8481
180002	17.9669	17.5798	19.7742	18.4114
180004	17.2581	17.7149	18.0494	17.6734
180005	21.1390	22.4634	23.4941	22.1458
180006	11.4398	10.3400	11.2872	11.0389
180007	17.6776	17.9491	18.6823	18.0973
180009	21.4730	21.0608	21.7746	21.4458
180010	19.1100	19.6311	19.4210	19.3847
180011	17.1050	19.0526	22.6798	19.8513
180012	18.7223	19.0646	19.6614	19.1485
180013	18.2354	19.7418	19.9690	19.3345
180014	21.4856	21.3361	22.9674	21.8678
180016	19.8892	21.1458	19.7132	20.2640
180017	15.4140	15.6583	16.7649	15.9422
180018	17.1692	15.4892	17.2357	16.6084
180019	17.3970	17.8285	19.0883	18.1044
180020	17.7288	18.0111	19.3978	18.3483
180021	15.4580	17.0618	16.5376	16.3552
180023	15.8803	17.4717	19.0574	17.4610
180024	16.1731	16.5040	19.6313	17.2961

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
180025	14.1841	15.4180	17.1875	15.5888
180026	14.6804	15.0118	13.9959	14.5545
180027	16.4116	17.5286	19.6928	17.8399
180028	19.5276	15.7005	26.1723	19.5534
180029	17.7729	17.7248	20.0357	18.4826
180030	17.3430	17.9543	17.5043	17.5959
180031	13.9844	13.1848	17.1003	14.4541
180032	16.8318	17.2784	17.2362	17.1383
180033	17.7344	15.4131	17.0498	16.6984
180034	15.3369	16.3991	17.0349	16.2188
180035	20.1305	21.3666	22.6728	21.3628
180036	19.8398	20.1860	20.6951	20.2522
180037	19.9737	21.2184	21.0177	20.7450
180038	17.7626	18.5923	19.0457	18.4790
180040	19.5337	21.2229	22.1332	20.9525
180041	15.0785	16.3699	17.5950	16.3724
180042	16.7691	17.1519	15.5660	16.4438
180043	16.8027	14.6526	17.0419	16.0656
180044	18.5571	19.4984	21.1057	19.7654
180045	17.7130	20.8455	20.7850	19.9661
180046	19.2523	21.2080	20.8544	20.4279
180047	16.2304	18.6938	17.8625	17.5927
180048	18.3442	17.7816	18.3151	18.1431
180049	16.4319	16.5459	17.0422	16.6742
180050	17.8540	17.1493	19.4583	18.1528
180051	16.3960	17.5441	17.7358	17.2163
180053	15.9284	15.8994	17.3167	16.3733
180054	19.4858	20.0946	17.4354	19.0288
180055	15.2663	15.8422	16.6072	15.8890
180056	17.0056	17.5881	18.6075	17.7242
180058	15.9685	14.5355	14.7900	15.0323
180059	13.3955	14.7032	17.2542	14.9522
180063	13.1036	12.4448	14.7338	13.4418
180064	15.2424	15.5066	16.3894	15.6781
180065	12.0629	11.1934	11.0966	11.4164
180066	19.2981	19.8956	19.4875	19.5598
180067	20.6322	20.1712	20.2762	20.3589
180069	17.7911	16.2916	19.0443	17.6808
180070	13.1923	15.9362	15.4643	14.7849
180072	16.9021	17.2347	17.0576	17.0759
180078	21.1170	21.7116	22.2802	21.7169
180079	15.1636	15.9048	18.1683	16.3817
180080	16.4989	16.6428	17.5659	16.9072
180087	14.9167	15.6089	16.2378	15.5798
180088	22.0374	22.1774	22.8908	22.3519
180092	18.2405	18.3597	18.8964	18.5113
180093	17.0132	17.8492	17.6961	17.5099
180094	13.5490	13.6233	14.3306	13.8326
180095	13.8021	13.9050	15.4478	14.3114
180099	13.3631	13.2991	14.0464	13.5559
180101	18.4883	*	20.2958	19.4148
180102	17.9618	18.5240	16.6998	17.7006
180103	19.8965	20.3490	20.8866	20.3712
180104	18.9281	19.3922	20.3023	19.5481
180105	15.2394	16.6997	18.2976	16.6579
180106	14.3505	15.2895	15.5278	15.0462
180108	14.8187	14.4740	14.8720	14.7266
180115	16.7003	16.9096	18.0951	17.2235
180116	18.0392	18.6077	18.1923	18.2836
180117	17.7857	23.0192	20.7961	20.3977
180118	15.8597	16.9250	17.9017	16.8657
180120	16.1591	15.3115	16.4226	15.9318
180121	15.0983	20.0494	16.9570	17.2427

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
180122	18.5094	18.1930	18.7549	18.4922
180123	21.0613	21.1067	21.8227	21.3332
180124	17.4994	18.8487	19.7138	18.6761
180125	19.6416	14.9314	22.6161	18.1828
180126	12.9228	14.3551	14.8501	14.0804
180127	19.2581	17.6365	18.0498	18.2667
180128	17.6385	18.2817	18.7194	18.2299
180129	16.8378	22.3536	15.6637	17.9690
180130	19.8192	20.6450	21.9268	20.8000
180132	17.7744	19.5884	19.4233	18.9093
180133	21.6794	21.7800	23.2679	22.2101
180134	13.1935	14.5387	16.5901	14.7149
180136	17.3542	*	*	17.3542
180138	19.3692	20.2102	19.8524	19.8199
180139	18.7198	20.5350	20.3816	19.9038
180140	16.8152	15.2719	14.6466	15.5892
180141	20.9820	23.8930	23.0957	22.5668
180142	*	20.751	*	20.7510
180143	*	*	21.3197	21.3197
190001	17.6832	18.1514	18.8583	18.2414
190002	19.1924	19.8834	20.6057	19.8935
190003	19.7749	19.9121	19.5115	19.7281
190004	17.7710	18.3620	19.6755	18.6227
190005	17.2422	17.5161	18.6994	17.8286
190006	17.8036	17.5911	17.7333	17.7115
190007	13.8189	14.4720	15.8753	14.7770
190008	18.6664	19.2456	22.4797	20.0804
190009	15.3555	15.9731	16.0395	15.7936
190010	16.2805	16.5020	17.7616	16.8604
190011	15.9534	15.6351	15.7319	15.7701
190013	16.8181	15.5019	16.7770	16.3476
190014	17.0959	17.8015	18.6929	17.8513
190015	18.6266	18.9896	19.7673	19.1223
190017	16.2393	17.5381	19.8449	17.8836
190018	15.0668	11.1898	13.1355	13.0348
190019	18.5257	18.3788	18.6473	18.5189
190020	17.5256	17.6840	18.7252	17.9732
190025	18.6369	16.8686	18.1892	17.9111
190026	18.1622	18.5015	18.8895	18.5256
190027	17.0827	17.4761	18.3203	17.6149
190029	16.5239	19.1967	18.7344	18.0923
190034	16.8503	18.0754	19.2007	18.0146
190036	20.1780	20.0300	21.1870	20.4494
190037	17.6945	19.9878	14.1323	17.4581
190039	19.4713	19.0376	17.8217	18.7156
190040	21.4634	21.7376	23.0537	22.0787
190041	17.6646	17.9535	17.2344	17.5871
190043	15.5580	15.5618	15.5645	15.5614
190044	17.2892	17.4471	17.6788	17.4765
190045	21.6107	21.2853	22.0065	21.6574
190046	19.7964	20.4458	20.2414	20.1666
190048	16.6683	16.8136	16.6848	16.7218
190049	17.2280	17.7417	18.5902	17.8611
190050	16.1980	16.2854	16.9053	16.4718
190053	13.2159	13.0080	13.4768	13.2412
190054	19.1738	18.9059	17.7269	18.6351
190059	15.6942	15.8373	17.8651	16.5018
190060	14.7186	17.8443	19.9121	17.2297
190064	20.4482	18.2466	19.9873	19.5473
190065	20.9927	18.3091	18.3050	19.0764
190071	14.4827	16.4138	16.3822	15.7772
190077	15.7805	16.5536	16.8829	16.4072
190078	14.8826	16.9383	19.5879	16.9873

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
190079	17.7120	17.9403	18.1929	17.9449
190081	15.3198	14.9707	14.7919	15.0273
190083	18.8895	18.4951	16.2970	17.9487
190086	15.8694	16.5074	17.6237	16.6689
190088	20.5531	19.9362	20.4725	20.3095
190089	13.0503	15.0395	15.2055	14.4221
190090	16.6664	16.2351	19.8201	17.5803
190095	16.2287	17.3258	17.3637	16.9543
190098	20.4897	21.0847	22.5793	21.3421
190099	19.9018	19.0635	19.0545	19.3385
190102	20.0300	20.7870	21.0423	20.6389
190103	12.1389	14.4158	15.6415	14.0050
190106	18.5813	18.5908	19.9117	19.0267
190109	15.5767	15.8187	16.3641	15.9327
190110	15.8052	15.7313	15.2652	15.5956
190111	19.7514	20.6508	20.2253	20.2164
190112	21.0232	22.0741	24.2806	22.3499
190113	12.5777	*	19.0411	16.0667
190114	12.6366	13.9209	13.4402	13.3357
190115	20.2473	22.7583	23.7462	22.1782
190116	15.5481	17.3757	18.3223	17.0452
190118	14.7876	16.3776	17.8543	16.2736
190120	13.9591	17.2309	17.6708	16.2867
190122	15.4793	15.3742	16.7189	15.8764
190124	20.6222	20.1206	22.8245	21.2142
190125	20.4517	19.8298	20.1401	20.1511
190128	20.4688	20.8770	21.1465	20.8466
190130	15.1467	14.0379	14.5586	14.5812
190131	20.7565	18.8958	19.7483	19.8133
190133	13.5383	15.1393	15.7834	14.7342
190134	12.1749	12.4507	*	12.3182
190135	21.6875	21.3454	23.1434	22.0401
190136	12.4091	15.1662	15.6286	14.4513
190140	14.2256	14.6829	14.8738	14.5954
190142	15.4861	16.2280	19.0464	16.8845
190144	16.2068	18.4405	18.3513	17.6419
190145	15.2345	16.2505	16.4402	15.9754
190146	21.2825	21.9607	20.6776	21.3057
190147	14.4345	14.7202	15.2732	14.8106
190148	16.6337	15.5338	19.4518	17.1031
190149	17.5997	16.4722	16.5153	16.8165
190151	14.7333	15.5210	16.2783	15.5127
190152	22.2070	22.0319	22.7142	22.3160
190156	15.7478	16.0442	17.6573	16.4812
190158	20.4637	20.4078	21.6307	20.8104
190160	17.1003	18.4662	19.3139	18.3349
190161	15.5737	15.9280	15.7807	15.7581
190162	20.6143	20.1962	20.9645	20.5966
190164	15.1783	18.2379	19.0473	17.3930
190167	16.6681	17.7611	15.5795	16.5709
190170	14.1750	14.5222	16.2045	15.0173
190173	23.6398	23.0934	*	23.4298
190175	19.3625	20.4580	22.2470	20.7017
190176	24.0574	22.2316	21.7051	22.5987
190177	18.6715	19.7794	20.3679	19.5997
190178	11.0657	12.0372	*	11.5413
190182	20.2855	20.7102	23.1997	21.3232
190183	16.7671	16.0752	16.7402	16.5275
190184	17.2044	19.8436	18.6583	18.5582
190185	20.1444	20.5852	20.5454	20.4315
190186	18.7568	17.4078	16.7272	17.7093
190190	17.4642	15.8985	13.7951	15.8564
190191	20.4975	19.6911	19.7218	19.9785

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
190196	17.9225	18.6138	19.1961	18.6202
190197	19.5569	20.2082	20.5377	20.1371
190199	16.0637	15.3522	17.8288	16.5088
190200	22.0391	21.6852	22.3510	22.0311
190201	18.7079	19.7421	21.5656	20.0412
190202	*	*	22.4701	22.4701
190203	21.7350	21.7931	23.0636	22.1708
190204	21.4624	20.5784	22.9134	21.6176
190205	19.6587	19.3737	18.8750	19.3122
190206	21.7012	21.3307	21.7867	21.6067
190207	20.5082	19.0216	20.7024	20.0851
190208	20.0065	16.9641	17.6834	18.1192
190218	19.7518	19.2992	20.7290	19.9128
190231	15.8287	17.7247	*	16.7208
190236	19.3395	21.1982	22.5796	21.1124
190238	*	20.6799	*	20.6799
190239	*	19.7601	*	19.7601
190240	*	14.3579	16.0112	15.2482
200001	18.0527	18.2513	19.9438	18.7634
200002	19.3629	22.3035	22.3272	21.3905
200003	16.9566	18.4141	18.8570	18.0991
200006	17.6586	21.0922	24.1167	20.8621
200007	18.7992	18.1681	19.4177	18.7699
200008	21.7489	21.5556	24.2833	22.5897
200009	22.2280	21.4763	23.2456	22.3157
200012	18.3484	19.1047	20.9187	19.4746
200013	18.0566	17.9378	20.2192	18.8221
200016	18.0866	17.1187	16.2939	17.1580
200017	17.2930	*	*	17.2930
200018	18.5397	17.8675	20.6104	19.0069
200019	19.2348	19.9245	21.3003	20.1669
200020	22.4526	22.3355	24.8195	23.2627
200021	19.9133	20.7361	22.4038	21.0287
200023	16.1707	20.2063	*	18.0379
200024	19.4329	20.8336	21.2346	20.5158
200025	20.2259	20.4165	21.6002	20.7762
200026	18.1194	17.9021	21.4758	18.9050
200027	18.5659	19.4220	20.2146	19.4316
200028	19.5708	18.8763	19.9926	19.4914
200031	16.2217	16.1641	17.3915	16.5880
200032	18.9315	19.4613	20.8973	19.7659
200033	21.8634	22.4685	23.6538	22.6396
200034	20.1519	20.4941	21.3303	20.6756
200037	18.6713	20.3015	19.7768	19.6048
200038	23.3851	21.2632	22.9629	22.5227
200039	19.8589	20.1508	21.0884	20.3830
200040	19.5503	18.9580	19.5917	19.3665
200041	19.3563	18.8131	20.3761	19.5462
200043	16.7224	19.4295	19.8833	18.5621
200050	20.1214	20.2014	14.6387	17.8681
200051	22.1525	22.0712	*	22.1031
200052	17.2099	17.6271	19.9239	18.2260
200055	18.8422	18.5983	19.4998	18.9700
200062	17.2273	18.4279	18.4038	18.0038
200063	19.9331	21.2121	22.5278	21.2360
200066	17.0289	17.0570	18.7143	17.6294
210001	20.4841	18.6617	21.5280	20.1745
210002	19.9219	23.5132	21.1426	21.7024
210003	20.3446	26.0447	21.6625	22.4257
210004	24.2909	24.9760	*	24.6345
210005	21.4929	21.3829	23.8670	22.2506
210006	18.9436	19.3682	20.8607	19.7283
210007	23.1007	23.8840	23.4582	23.4837

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
210008	21.1768	21.2895	21.0767	21.1826
210009	20.5447	20.7479	20.8476	20.7179
210010	18.7197	19.5908	19.7917	19.3735
210011	21.4862	21.4043	20.0662	20.9726
210012	20.7203	21.3977	24.0745	21.9907
210013	19.7288	19.4505	23.1649	20.7921
210015	16.1912	18.7448	23.9651	19.4078
210016	23.8739	26.5193	*	25.1634
210017	18.8928	18.5079	18.2963	18.5724
210018	22.2135	22.8553	23.6442	22.8975
210019	19.3046	20.6025	21.5429	20.4724
210022	22.6389	24.5744	25.6728	24.3137
210023	23.1950	22.9989	24.4815	23.5799
210024	20.6011	24.4280	24.7858	23.2181
210025	19.5876	21.2769	21.4910	20.6428
210026	12.1348	13.8668	20.7986	14.8993
210027	17.6855	17.1060	16.2219	17.0429
210028	19.6408	19.4157	20.4027	19.8293
210029	21.2167	25.4939	24.7605	23.8903
210030	21.7403	20.9574	21.9547	21.5644
210031	16.2299	*	*	16.2299
210032	17.7228	20.1955	20.0825	19.3625
210033	20.8053	23.7588	22.8303	22.4103
210034	15.7322	19.4144	22.6812	19.1023
210035	20.2731	20.8317	21.6662	20.9231
210037	18.3072	20.5528	19.2811	19.3731
210038	23.4971	24.9762	25.9701	24.7755
210039	19.9901	21.3559	23.3583	21.5884
210040	21.5014	23.4252	23.1960	22.7040
210043	19.6474	22.4000	22.9504	21.5561
210044	22.5781	23.0917	22.9540	22.8695
210045	11.6086	12.1467	13.5654	12.4021
210048	23.0537	24.6921	24.9381	24.2387
210049	19.0821	19.3022	21.1056	19.8459
210051	22.4335	23.6476	24.8949	23.6510
210054	22.3559	23.2730	25.1694	23.5831
210055	29.2539	26.5272	23.8025	26.3168
210056	19.2662	22.9593	23.8915	21.9932
210057	23.8289	26.0076	*	24.8719
210058	22.0753	16.3191	17.4250	18.5418
210059	22.6766	25.6052	*	23.8855
210060	*	26.5846	26.4566	26.5245
210061	17.2240	16.1931	20.8975	18.1853
220001	21.9369	22.9064	23.4091	22.7509
220002	24.1285	24.5840	25.3171	24.6486
220003	16.9246	17.9319	17.6069	17.4814
220006	22.3085	22.6337	23.5624	22.8309
220008	24.4691	22.0796	23.0806	23.1592
220010	21.8582	22.0067	23.8256	22.5598
220011	26.1827	29.5290	24.8039	26.6476
220012	32.0829	31.2303	30.4104	31.2159
220015	22.5773	23.1893	24.1348	23.2890
220016	23.3750	23.0951	24.5411	23.6644
220017	22.4605	25.1568	25.9000	24.3877
220019	19.5613	19.8551	19.9268	19.7870
220020	21.4152	22.4295	22.5375	22.1352
220023	16.1885	*	*	16.1885
220024	21.5363	21.9316	23.8620	22.4506
220025	20.7882	22.8593	22.8936	22.1783
220028	22.8036	21.0630	24.0441	22.5673
220029	23.1509	25.6560	26.3117	25.0100
220030	18.5441	18.7429	19.3387	18.8705
220031	30.2430	29.3091	28.3832	29.0231

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
220033	20.0695	20.3609	22.3195	20.8616
220035	21.6396	23.1892	24.5685	23.0612
220036	24.6470	24.4091	24.9637	24.6635
220038	22.6518	22.3162	22.4302	22.4673
220041	23.4720	27.5034	28.6303	26.3941
220042	25.0779	26.0473	28.4675	26.3871
220046	22.7068	23.3149	23.8578	23.2791
220049	26.0025	27.2689	25.2174	26.1330
220050	22.0144	22.5265	23.3330	22.6222
220051	21.1033	21.7357	22.4826	21.7398
220052	23.7650	23.5225	24.4403	23.8995
220053	19.1280	*	*	19.1280
220055	21.3743	*	*	21.3743
220057	25.3902	25.8064	26.2945	25.8083
220058	19.9369	26.8345	21.6814	22.7654
220060	28.0843	28.0794	28.1888	28.1190
220062	20.4685	20.2254	16.0585	19.0019
220063	20.3951	20.8079	21.7336	21.0041
220064	22.3260	22.7497	23.8859	22.7342
220065	20.1364	20.1424	21.5556	20.6267
220066	20.7826	23.4477	24.5463	22.8901
220067	26.4443	27.5405	27.9807	27.2636
220070	19.7528	20.9128	21.0606	20.5677
220071	25.6184	27.4151	27.4906	26.8301
220073	25.6025	26.1328	27.4458	26.3872
220074	25.6390	24.3057	24.8908	24.8286
220075	22.8057	22.5329	24.5769	23.3112
220076	22.6668	23.2795	24.1224	23.3492
220077	25.2646	26.1545	27.1503	26.1736
220079	22.6256	22.0769	25.7305	22.9418
220080	21.5238	22.1971	22.9911	22.2508
220081	29.1726	29.6682	29.6399	29.4983
220082	21.6726	22.1453	22.9171	22.2513
220083	23.9156	22.5815	27.2605	24.4264
220084	23.6641	25.3761	25.8300	24.9680
220086	23.8705	26.7778	28.7276	26.2967
220088	22.9067	23.4258	25.0671	23.8081
220089	23.0965	25.4106	25.3521	24.5662
220090	22.0041	23.3049	25.0628	23.4549
220092	18.5239	24.7905	*	20.9405
220095	21.4831	21.7851	22.4924	21.9294
220098	21.5906	23.1547	24.7180	23.1447
220100	25.7077	27.5841	26.8001	26.6854
220101	25.9204	27.0711	27.9184	26.9502
220104	28.0021	28.7258	*	28.3658
220105	21.4129	21.9185	23.2210	22.2352
220106	25.6577	25.9277	28.1034	26.6044
220108	21.9115	23.4975	24.5939	23.3257
220110	28.7071	29.1648	30.2500	29.3820
220111	23.8066	24.7510	26.7336	25.0953
220116	26.1662	32.0049	28.4236	28.6928
220119	23.3216	23.8785	24.4507	23.8686
220123	25.8994	32.4678	28.8325	29.1153
220126	22.5218	23.6045	23.8123	23.3172
220133	25.4596	29.3911	29.8366	28.1948
220135	25.6522	28.3648	29.6837	27.9677
220153	22.9592	*	*	22.9592
220154	22.4770	21.1563	23.3590	22.3695
220163	29.1143	29.2299	29.3552	29.2328
220171	24.5553	24.9261	26.9048	25.5207
230001	19.8020	20.0438	23.3051	20.9963
230002	22.7991	23.0439	24.3115	23.3442
230003	19.8420	21.2215	21.6493	20.9088

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
230004	23.1036	20.5005	22.4538	21.9617
230005	18.5644	17.0943	20.5596	18.6769
230006	19.1041	20.4978	21.1974	20.2494
230007	15.5538	*	*	15.5538
230012	15.0803	*	*	15.0803
230013	20.8018	22.2211	20.0954	21.0266
230015	20.1104	20.6464	21.9499	20.8811
230017	22.2822	22.9755	25.7900	23.6501
230019	22.2622	23.6674	23.8779	23.3381
230020	22.1280	21.8526	28.8386	23.8749
230021	18.9636	19.8256	20.5690	19.8347
230022	18.8006	21.9129	21.7265	20.8153
230024	23.7326	24.9664	26.2155	24.8592
230027	14.6950	19.6393	22.5114	18.5396
230029	19.4911	22.1782	25.2459	22.2502
230030	18.3916	18.6406	19.1742	18.7416
230031	19.3162	19.9465	19.4676	19.5690
230032	21.8845	24.8930	22.5952	23.1148
230034	19.0473	19.4366	17.9276	18.7511
230035	17.5109	17.7490	20.5906	18.5317
230036	23.2119	23.8398	25.2015	24.1096
230037	20.4747	23.2751	22.7382	22.1469
230038	23.5251	21.9692	21.4546	22.2952
230040	21.4393	20.7841	20.2451	20.8039
230041	20.3131	21.7364	23.2870	21.7251
230042	22.1043	21.3870	19.8523	21.0979
230046	25.5696	25.3206	26.1787	25.6837
230047	21.5381	22.3595	23.7737	22.5475
230053	25.4968	26.8917	23.3066	25.2933
230054	20.6963	20.8014	17.6968	19.8741
230055	20.7932	20.8492	20.8930	20.8452
230056	16.0766	17.8091	17.3516	17.0331
230058	20.4165	21.0303	21.6619	21.0283
230059	19.9240	20.7092	20.5651	20.3916
230060	19.8021	19.8987	21.0368	20.2439
230062	17.1540	18.8039	18.2283	18.0500
230063	20.4171	*	*	20.4171
230065	22.3459	22.7416	23.3414	22.8607
230066	22.1768	23.0475	23.2790	22.8376
230069	23.2076	24.2470	25.0212	24.1384
230070	20.2505	21.5666	21.1658	21.1081
230071	22.9052	23.1337	23.6398	23.2244
230072	20.6944	20.4456	22.6533	21.2484
230075	20.0545	22.5866	22.3632	21.5991
230076	24.4547	24.7010	26.7244	25.2068
230077	21.0178	20.2823	22.6153	21.3059
230078	17.5577	17.9868	19.1638	18.2565
230080	19.7687	20.2104	19.1810	19.7086
230081	19.0345	19.0199	20.0464	19.3283
230082	18.2992	19.0419	18.2165	18.5095
230085	20.2096	23.4996	24.5765	22.7898
230086	18.9420	20.1730	20.1060	19.7404
230087	18.9034	19.9700	20.6619	19.7714
230089	23.9100	22.6994	22.7774	23.0814
230092	20.0145	20.7738	22.2629	21.0588
230093	20.4655	20.6314	21.0274	20.7091
230095	17.3313	17.6444	18.0582	17.6864
230096	22.8410	22.7785	24.3004	23.2947
230097	21.2854	21.1254	22.5006	21.6504
230099	21.1933	21.7513	21.7402	21.5696
230100	17.1336	17.3842	18.1823	17.5576
230101	20.0932	20.5315	22.5159	20.9964
230103	22.7696	11.3429	18.5254	17.4039

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
230104	23.1457	24.1238	25.5606	24.3812
230105	21.5210	22.6098	23.0086	22.4180
230106	20.7997	21.6825	22.9909	21.8109
230107	16.5966	17.1386	18.9985	17.6147
230108	18.8631	20.3437	21.4592	20.2385
230110	18.9825	19.7262	20.0544	19.5843
230113	14.9411	*	*	14.9411
230115	18.4050	19.6281	21.0361	19.6522
230116	16.5419	14.5692	15.6064	15.5368
230117	25.9318	25.6797	25.4341	25.6737
230118	21.3028	20.6797	20.2770	20.7229
230119	21.1918	22.6555	23.9898	22.6112
230120	18.5264	20.3306	20.6105	19.6370
230121	20.3158	21.3342	21.0568	20.9014
230122	20.9078	*	*	20.9078
230124	20.3608	18.9981	20.9641	20.0945
230128	24.9081	24.0724	24.4952	24.4850
230130	23.5170	22.1775	23.5123	23.0660
230132	26.6386	26.1946	27.3497	26.7222
230133	17.6894	17.1058	19.0770	17.9441
230135	22.5258	20.5637	18.4193	20.8744
230137	19.1813	*	*	19.1813
230141	22.1299	22.4570	24.4560	22.9910
230142	22.2940	23.5621	24.9830	23.5261
230143	16.3043	16.7948	18.2700	17.1074
230144	22.1108	23.4237	23.3295	22.9371
230145	20.2542	19.2638	17.9811	19.0315
230146	20.5044	21.2260	22.3838	21.3821
230147	21.8496	23.2755	*	22.5377
230149	20.7691	18.8005	19.9577	19.8029
230151	22.1713	23.3967	24.1404	23.2068
230153	19.5633	18.7403	20.0098	19.4472
230154	15.4456	15.4362	16.7152	15.8739
230155	17.2076	20.5409	20.9053	19.4860
230156	24.7587	25.6228	27.2254	25.8423
230157	20.3667	17.3571	*	18.9586
230159	20.0749	*	*	20.0749
230162	21.4636	21.7148	22.7984	21.9769
230165	23.0106	23.8881	24.5193	23.7930
230167	21.5048	22.9745	24.1064	22.8649
230169	23.0652	24.3874	28.1039	25.0117
230171	13.3863	17.1282	16.1129	15.4610
230172	20.6417	21.4675	22.1709	21.4477
230174	23.0272	22.7304	23.5025	23.0851
230175	16.8909	*	14.4932	15.4643
230176	22.7772	23.8204	24.6518	23.7400
230178	16.9156	17.3030	17.3428	17.1968
230180	15.8769	18.5744	19.6062	17.9856
230184	19.0604	19.7717	20.4831	19.7582
230186	19.5337	15.7837	19.1289	18.1131
230188	15.7112	16.2975	16.8687	16.3031
230189	16.6838	17.9218	19.1990	17.9352
230190	26.8196	26.4687	24.4643	25.9234
230191	19.0013	18.4861	20.6633	19.3446
230193	19.7066	19.8287	21.5358	20.3443
230195	21.7775	22.9228	23.4647	22.7456
230197	24.0184	24.0854	25.4494	24.4929
230199	19.4451	20.6580	22.4592	20.8791
230201	17.2141	18.0787	18.2486	17.8664
230204	25.4181	23.4966	24.5127	24.4525
230205	14.3788	15.9314	18.1551	16.1081
230207	20.6375	21.2483	20.9059	20.9181
230208	16.0733	16.7454	17.4925	16.7635

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
230211	18.6744	21.8581	21.1245	20.4277
230212	23.3021	24.2611	24.6420	24.0563
230213	15.1908	15.5469	17.1062	15.9226
230216	20.3359	21.0710	22.2137	21.1969
230217	21.2707	22.2698	24.1455	22.5496
230219	19.1549	20.0442	18.1277	19.1400
230222	22.1785	21.9711	23.2545	22.4802
230223	21.1528	22.6887	25.2666	22.9884
230227	23.7259	22.3155	25.8826	23.9496
230230	22.2385	22.3097	22.1703	22.2333
230235	16.8684	17.7197	18.3341	17.6456
230236	24.3835	25.9676	25.2273	25.2169
230239	18.0942	17.8168	18.9790	18.2974
230241	19.1000	20.7297	20.4217	20.0924
230244	21.7413	22.2697	23.1175	22.3742
230253	20.5945	21.0433	22.7706	21.4304
230254	21.9402	22.6335	23.3714	22.6370
230257	19.6982	21.3880	23.1794	21.3083
230259	22.2393	22.3969	23.1768	22.6077
230264	17.1319	17.4864	18.4075	17.6504
230269	23.3105	24.0992	24.3772	23.9435
230270	22.6187	22.5985	24.8925	23.3219
230273	22.9199	22.8715	24.1278	23.2898
230275	17.7487	20.8985	*	18.8231
230276	21.3722	25.8709	22.3313	22.8959
230277	23.1456	23.9771	24.2319	23.8212
230278	18.2110	*	*	18.2110
230279	17.6973	17.8074	18.3256	17.9471
230280	15.6654	18.3497	*	16.7057
230283	27.9480	22.5082	*	24.9202
230287	*	*	22.5420	22.5420
240001	24.6207	25.6936	26.6372	25.6759
240002	22.7981	23.2307	24.1694	23.4122
240004	25.1908	24.4030	25.6238	25.0604
240005	17.9563	20.3193	20.2389	19.4808
240006	25.1602	23.0715	25.7288	24.6342
240007	17.7625	19.0850	20.7189	19.1593
240008	20.2158	23.3783	22.7437	21.9832
240009	16.8965	17.1187	17.4518	17.1699
240010	23.6477	25.4752	28.3796	25.8852
240011	20.5192	21.5875	22.5188	21.5240
240013	20.3282	21.7544	25.1560	22.2201
240014	23.0025	24.2610	25.2306	24.1808
240016	20.4017	22.2011	23.3772	21.9959
240017	18.3585	18.9272	19.3431	18.8677
240018	20.8501	18.4268	23.6092	20.7339
240019	22.1501	23.1477	24.0613	23.1411
240020	21.1937	20.8849	20.6378	20.8948
240021	18.7515	20.1457	19.0469	19.2586
240022	21.7889	21.3234	23.0394	22.0529
240023	21.5087	22.8224	22.3002	22.1691
240025	18.8345	20.0308	20.7672	19.8809
240027	19.1017	16.7758	18.3837	18.0732
240028	19.7918	25.1934	*	22.5025
240029	21.1329	20.0164	23.0440	21.3549
240030	18.8547	20.1653	20.9799	20.0254
240031	18.1566	19.3983	21.7620	19.6652
240036	22.2460	22.1721	22.5423	22.3294
240037	19.2345	20.1195	21.4275	20.2550
240038	25.3061	24.3957	26.3886	25.3874
240040	20.4813	23.1352	22.8191	22.1112
240041	19.2864	21.8655	21.9054	20.9373
240043	17.7335	16.9859	18.2388	17.6591

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
240044	18.8411	20.3339	22.5750	20.4995
240045	21.1396	24.1557	24.2936	23.2125
240047	22.6152	23.8098	25.3136	23.8879
240050	25.2983	21.6499	23.1719	22.7044
240051	19.9195	22.5855	23.2612	21.9129
240052	20.7749	*	22.3485	21.5706
240053	22.9611	23.8693	24.2783	23.7568
240056	23.4226	23.7139	24.8549	24.0398
240057	24.2159	24.8686	25.4292	24.8727
240058	14.9697	18.4009	19.0506	17.2677
240059	23.6215	23.7808	25.3847	24.2488
240061	27.2603	25.9951	27.9151	27.0571
240063	23.7866	24.4031	25.4760	24.5591
240064	23.2860	22.8578	24.6785	23.6296
240065	12.7867	14.8734	14.4623	14.0357
240066	23.0698	24.1143	25.5163	24.2946
240069	19.8282	21.7991	23.3241	21.6103
240071	20.2101	21.2463	22.5319	21.3438
240072	21.1824	20.9529	21.5455	21.2291
240073	16.0840	17.3559	17.9013	17.1144
240075	21.2654	21.3357	21.9160	21.5185
240076	21.8795	22.3280	23.6130	22.6447
240077	15.3794	20.3445	22.1509	19.1544
240078	23.9150	25.1082	25.9495	25.0087
240079	18.4338	18.8345	18.2929	18.5204
240080	24.3399	25.5619	26.0031	25.2885
240082	18.3555	18.7995	20.2018	19.1212
240083	19.7637	21.0317	22.3289	20.9906
240084	19.4739	21.7421	23.1951	21.4482
240085	22.5736	20.9778	20.7535	21.3852
240086	16.9392	18.1401	18.1497	17.7863
240087	18.8352	21.3323	21.2116	20.4135
240088	21.6858	23.1056	24.6260	23.0939
240089	20.7239	21.1989	21.3949	21.1104
240090	19.2968	19.2166	21.0856	19.8725
240093	18.7092	20.2400	20.7138	19.9194
240094	20.9446	22.0247	22.5923	21.8995
240096	20.1644	21.0417	20.2992	20.4825
240097	24.2662	27.9496	29.7597	27.1621
240098	21.3467	24.2296	23.9626	23.2314
240099	14.4649	15.4964	18.8139	15.9924
240100	20.8302	20.8325	24.1875	21.9081
240101	19.2120	19.9837	22.1329	20.4409
240102	14.6067	16.3659	15.5114	15.4871
240103	19.1540	18.7510	21.0182	19.5968
240104	23.2178	23.5351	25.2485	24.0080
240105	14.3965	*	*	14.3965
240106	23.5148	23.5005	23.9677	23.6780
240107	20.3983	20.9004	21.2163	20.8360
240108	15.3547	18.2427	17.6500	16.9347
240109	13.5537	16.3216	15.1369	14.9110
240110	19.4828	21.0277	21.7340	20.7301
240111	17.2100	17.8617	19.9712	18.3046
240112	15.8350	16.6244	17.2437	16.5628
240114	16.2505	17.3682	18.3415	17.5274
240115	23.7765	23.8675	24.6174	24.0872
240116	16.6731	18.3520	17.3460	17.3960
240117	18.0636	17.9941	18.7656	18.2986
240119	20.6126	21.8289	23.0230	21.7338
240121	23.4018	22.2266	22.4858	22.6970
240122	19.1811	21.2876	20.7795	20.4095
240123	16.5098	18.3941	18.9494	17.8731
240124	19.4400	20.4728	21.2023	20.3644

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
240125	12.3627	14.9708	17.3846	15.0136
240127	15.8966	17.9724	16.4294	16.7198
240128	17.2513	16.3608	17.5611	17.0478
240129	14.4212	16.5209	17.7242	16.1756
240130	14.9399	16.4271	17.7634	16.3549
240132	23.0669	23.1452	24.4301	23.5642
240133	19.2126	19.5293	20.8958	19.9049
240135	14.3069	15.7015	15.6298	15.1560
240137	20.3750	21.5073	21.6644	21.1797
240138	15.2062	16.7332	18.9731	16.7753
240139	20.8053	20.5496	21.8580	21.0743
240141	23.8066	23.1009	23.6622	23.5109
240142	25.2770	29.2238	24.0719	25.9878
240143	16.6172	20.4266	20.7307	19.0810
240144	18.2604	21.4469	23.1661	20.7059
240145	17.2778	19.0689	17.6747	18.0668
240146	16.0652	16.5412	17.3275	16.6788
240148	18.8779	19.5204	19.5372	19.2785
240150	13.8786	20.8331	23.3857	18.4647
240152	21.1678	22.4744	24.1818	22.6586
240153	16.5412	19.3336	17.7399	17.7721
240154	17.5769	21.5052	21.5859	20.1583
240155	19.8762	20.9385	23.6944	21.5112
240157	17.4168	13.7309	*	15.5390
240160	15.9492	15.9014	16.4990	16.1163
240161	15.7996	16.8809	18.0542	16.8888
240162	16.6292	19.1542	19.3296	18.3301
240163	18.8320	20.4760	22.2009	20.3835
240166	17.3233	19.4131	19.4496	18.7799
240169	16.6725	16.3958	*	16.5195
240170	18.8762	20.3779	21.5994	20.2122
240171	17.2886	18.5172	19.6732	18.5083
240172	18.2852	20.8606	20.3699	19.7027
240173	17.2655	18.5187	18.3183	18.0300
240179	17.5116	20.4004	17.7557	18.4699
240184	15.3793	16.8917	17.6979	16.5493
240187	19.9230	21.2736	23.2471	21.4869
240193	17.8226	18.4664	*	18.1403
240196	24.3472	25.3479	26.1827	25.3447
240200	14.3415	14.9076	18.7517	15.8336
240207	24.1127	25.2814	26.1748	25.2384
240210	24.2218	24.5664	25.3031	24.7274
240211	19.7399	30.6260	34.7849	25.7741
250001	18.4233	19.2756	20.2019	19.2920
250002	17.2501	18.6938	19.6081	18.5060
250003	17.6539	16.7570	18.7331	17.7215
250004	17.8868	18.3860	19.2913	18.5189
250005	12.5993	12.5834	13.7341	13.0041
250006	16.9048	17.5192	19.6894	17.9911
250007	19.2913	19.7562	20.9757	19.9959
250008	14.1760	15.8506	15.8096	15.2607
250009	18.5610	17.7283	17.1686	17.8180
250010	13.3905	14.6101	16.0233	14.5948
250012	14.1623	16.7579	17.4032	16.1420
250015	13.5274	11.7249	16.6522	13.7345
250017	17.9410	20.5976	18.8850	19.0991
250018	11.9311	13.1687	14.7291	13.0932
250019	16.7425	18.0956	19.9070	18.3382
250020	13.4476	16.2698	19.6575	16.1595
250021	9.4318	10.5844	12.7242	10.6438
250023	13.9116	12.3434	13.8210	13.3756
250024	12.7127	12.9899	14.8394	13.4135
250025	19.0390	20.3625	21.9075	20.5374

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
250027	14.9519	14.5445	15.1790	14.8945
250029	16.4834	16.0682	14.8216	15.7783
250030	17.3636	26.6173	25.5089	23.0726
250031	17.9715	18.3825	19.8779	19.1622
250032	17.1339	17.5957	*	17.3669
250033	17.8257	15.0941	16.9132	16.6524
250034	16.6988	17.0399	19.1875	17.6568
250035	15.2353	16.8349	18.3861	16.7093
250036	15.8445	16.1913	17.6247	16.6012
250037	15.4325	12.7156	14.3994	14.0734
250038	16.8454	17.7019	18.8434	17.7665
250039	14.1556	15.1409	16.4502	15.2329
250040	17.3430	18.3364	19.6513	18.4442
250042	16.3867	17.6531	18.3858	17.4884
250043	16.0729	16.6500	18.4025	16.9554
250044	16.1218	16.7321	19.1860	17.3262
250045	22.0839	21.8988	22.7225	22.2606
250047	13.3706	14.7461	*	13.9984
250048	16.8932	17.6649	19.4976	18.0474
250049	11.6715	12.1635	12.8275	12.2266
250050	14.3949	15.1159	16.0234	15.1991
250051	9.3464	10.4900	10.1212	9.9666
250057	15.9237	16.1838	16.3204	16.1462
250058	15.5327	15.7197	16.2623	15.8399
250059	16.2845	16.6494	17.7592	16.8861
250060	13.0301	16.1804	12.6893	13.8440
250061	11.0308	11.5108	12.0186	11.5214
250063	13.2540	13.3092	15.0894	13.8432
250065	12.8853	13.6904	15.0507	13.8065
250066	15.6760	16.1742	17.2711	16.3375
250067	16.4120	16.8522	18.3773	17.2393
250068	13.6768	13.4127	13.2644	13.4415
250069	17.8960	16.8980	18.2097	17.6479
250071	14.3781	12.3488	13.1934	13.2742
250072	18.2218	18.9487	21.0602	19.2655
250076	10.5098	*	*	10.5098
250077	12.2564	13.7404	13.9479	13.2870
250078	15.6336	15.9739	17.1972	16.2928
250079	16.2712	16.5835	16.1483	16.3337
250081	17.3325	19.0358	18.1848	18.1653
250082	16.0975	17.1427	17.3096	16.8599
250083	14.2634	16.6065	16.3054	15.6454
250084	17.0189	20.6429	21.0870	19.3827
250085	14.3797	15.4477	16.7377	15.5314
250088	17.8674	18.2736	19.3976	18.4880
250089	13.4238	14.3027	15.0238	14.2301
250093	15.2044	16.1506	16.8647	16.0778
250094	18.0852	18.5063	18.9681	18.5063
250095	17.0039	17.4217	18.4944	17.6334
250096	19.0688	19.0584	19.3630	19.1609
250097	16.9905	15.5741	16.3328	16.3172
250098	13.1341	18.3874	17.9180	16.1645
250099	14.8528	15.1265	15.9867	15.3437
250100	17.1682	17.8688	19.8795	18.3539
250101	18.4685	17.7194	17.6704	17.9924
250102	23.9329	18.9348	*	21.2970
250104	18.2502	18.7651	19.0165	18.6823
250105	14.5401	15.5133	16.1480	15.4020
250107	15.1496	15.0737	16.5635	15.5581
250109	22.1551	21.3867	24.5760	22.6981
250112	15.5610	16.3640	16.6447	16.1593
250117	16.1225	16.9787	15.9335	16.3432
250119	15.2199	16.1218	16.5700	15.9756

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
250120	15.3433	16.7182	18.1428	16.6322
250122	18.9417	19.2990	19.8033	19.3541
250123	18.8690	18.7863	22.1376	19.9106
250124	13.1823	13.2490	14.3551	13.5956
250125	20.8895	21.2660	21.3711	21.1778
250126	18.2355	21.9101	19.0168	19.6297
250128	14.0048	16.1418	15.9958	15.4423
250131	12.6056	12.4557	11.2470	12.0464
250134	17.0671	18.5142	21.4489	18.9054
250136	18.9689	21.3497	20.0333	20.0576
250138	18.4028	20.4550	19.3446	19.3211
250141	19.0113	19.6692	21.6835	20.2708
250145	10.2507	11.2120	11.2021	10.8489
250146	14.4924	14.7781	15.4061	14.8913
250148	18.0980	19.4233	23.1459	20.1203
250149	12.9569	15.2318	15.7537	14.6277
250150	*	21.8599	*	21.8599
260001	18.0971	20.1560	20.9602	19.7021
260002	22.1183	21.6597	23.4259	22.4118
260003	14.6553	15.4482	16.0721	15.3980
260004	13.0133	13.7035	15.2735	13.9164
260005	19.5554	23.9681	22.2119	21.8900
260006	19.7467	20.0994	22.1692	20.6408
260008	13.8495	16.8893	18.2114	15.8498
260009	18.5080	18.2863	19.0654	18.6237
260011	19.1027	19.5059	20.3279	19.6368
260012	14.3645	17.1662	17.3810	16.3363
260013	15.9884	16.1825	17.3772	16.4946
260015	16.5822	17.8817	18.0070	17.4241
260017	16.7916	16.9914	17.9796	17.2888
260018	12.0060	12.5301	13.6120	12.7676
260019	18.6113	*	18.3629	18.4928
260020	20.5142	20.2241	21.0314	20.5884
260021	22.1017	21.6237	23.3527	22.2918
260022	17.2462	17.7772	18.7707	17.9082
260023	16.4705	17.8649	18.5665	17.6119
260024	15.2356	15.7815	15.6095	15.5379
260025	15.4935	17.0965	18.2804	16.9786
260027	21.2977	22.0362	23.1505	22.1110
260029	19.7484	21.1858	20.1832	20.3332
260030	12.5118	11.9215	12.8349	12.4289
260031	19.4921	19.7249	22.5379	20.4276
260032	20.1988	19.6728	20.1817	20.0177
260034	17.4233	20.4902	20.5439	19.5050
260035	13.1065	13.0071	15.1611	13.8141
260036	16.7430	18.8104	19.9593	18.5490
260039	14.1866	14.6644	15.9689	14.9611
260040	17.3099	18.0140	18.5132	17.9641
260042	18.7567	18.7514	20.8821	19.5084
260044	15.9927	15.9206	16.7879	16.2332
260047	19.0112	19.2247	19.8178	19.3380
260048	20.0885	21.0602	22.4800	21.2299
260050	15.6908	16.8520	17.6687	16.7168
260052	18.0553	18.0914	19.1044	18.4413
260053	15.2236	16.5166	17.4110	16.3851
260054	20.0199	20.6242	23.0188	21.1083
260055	12.0118	15.4214	17.9547	14.9547
260057	17.4636	19.7144	16.5704	17.9947
260059	16.1000	17.0546	16.2074	16.4474
260061	14.7175	15.7112	17.1343	15.8685
260062	20.1477	21.3138	21.9287	21.1699
260063	18.2309	18.8973	19.7231	18.9234
260064	16.5934	17.8033	18.3749	17.5653

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
260065	19.4382	20.0975	20.6671	20.0563
260066	14.9640	15.3460	15.3139	15.2114
260067	14.2249	15.1837	14.5499	14.6334
260068	20.2418	19.4240	20.7947	20.1541
260070	*	13.9510	18.7384	16.1582
260073	14.2550	15.9182	16.9496	15.7508
260074	19.0350	19.8915	20.4033	19.8192
260077	18.6473	19.4482	20.5830	19.5877
260078	15.6381	14.9463	16.0586	15.5564
260079	14.2985	16.1453	16.4816	15.5347
260080	13.5384	14.6832	13.1617	13.7147
260081	21.0151	20.3053	20.2471	20.5212
260082	15.9407	15.9858	18.2853	16.7287
260085	20.4669	20.7051	21.5137	20.8993
260086	14.3164	15.2927	16.7579	15.4677
260091	19.9987	21.5464	22.0772	21.4012
260094	18.0085	18.5395	19.7308	18.8006
260095	19.6944	20.7292	21.6999	20.6994
260096	23.0282	22.5972	22.8259	22.8155
260097	16.5582	19.0632	18.6965	18.1123
260100	15.7047	16.6523	16.5439	16.3025
260102	20.1264	20.6361	21.2133	20.6454
260103	18.5957	19.7146	19.9144	19.3556
260104	21.0138	20.3176	21.6624	21.0040
260105	24.7223	24.8181	22.8005	24.0843
260107	19.8422	20.4269	22.5214	20.7581
260108	19.4609	20.0034	20.9029	20.1514
260109	13.9129	14.8181	15.9724	14.8936
260110	17.8375	18.3227	19.5633	18.5673
260113	14.6756	16.2223	16.1346	15.6436
260115	19.2259	17.4698	19.3873	18.6920
260116	16.2774	14.9812	16.0187	15.7314
260119	16.8836	17.2942	18.0725	17.4218
260120	16.3755	16.4904	17.6811	16.8504
260122	14.9697	16.0931	16.3700	15.8295
260123	14.6444	14.6822	15.2926	14.8761
260127	18.3572	18.4026	18.1342	18.2957
260128	13.0481	12.6414	13.2942	12.9961
260131	17.7686	18.4154	18.0395	18.0595
260134	16.2832	17.5127	17.1341	16.9643
260137	17.9531	19.4697	19.5976	19.0342
260138	22.6491	23.2364	23.1213	22.9952
260141	19.1580	19.1893	19.6237	19.3180
260142	17.1248	17.3084	18.2023	17.5590
260143	12.7867	13.9040	15.4688	13.9600
260147	14.0778	14.7769	15.8522	14.8908
260148	11.8674	11.3524	12.6651	11.9425
260158	12.3005	12.7699	13.9790	13.0499
260159	20.3177	19.7951	20.9636	20.3519
260160	15.8394	16.5792	18.4007	16.9325
260162	19.5655	21.4099	20.7331	20.5870
260163	16.4245	15.8593	16.8300	16.3731
260164	14.9372	15.1211	16.7279	15.6074
260166	20.1025	21.1224	22.4071	21.2079
260172	15.4163	16.0772	16.4854	15.9816
260173	12.8523	14.2090	15.5733	14.3947
260175	16.9023	17.5625	18.3632	17.6144
260176	26.8712	21.6044	23.2414	23.9990
260177	21.2578	21.9014	22.9091	22.0689
260178	19.6638	20.2796	20.8189	20.2016
260179	21.4906	22.7185	21.4470	21.8753
260180	19.5819	18.9881	19.5983	19.3863
260183	20.0712	21.3175	23.7057	21.6731

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
260186	19.3238	19.6026	21.0675	20.0580
260188	20.6388	22.5060	23.7475	22.1881
260189	11.3004	16.4233	*	13.8239
260190	18.5168	19.3419	21.6994	19.8001
260191	17.9812	18.1604	19.6784	18.6471
260193	21.1588	20.2577	22.2030	21.2172
260195	17.7237	19.7068	*	18.7154
260197	19.2840	20.5453	*	19.7846
260198	11.9751	19.7552	21.7926	16.7576
260200	20.5339	20.6888	21.7031	21.0210
260205	17.6210	*	*	17.6210
270002	28.9959	19.2387	19.0221	21.4738
270003	22.0995	22.5019	20.7277	21.7202
270004	19.6292	19.4834	20.1821	19.8074
270006	16.0238	17.0715	15.1006	15.9252
270007	11.3143	13.8824	15.5780	13.1858
270009	17.2292	20.8238	20.7031	19.5097
270011	20.2669	21.1653	21.8086	21.0508
270012	19.7346	19.7878	20.7913	20.0975
270014	19.0872	19.9859	20.4321	19.8518
270016	19.6717	18.6149	17.9984	18.9093
270017	21.0800	20.0152	22.1046	21.0660
270019	18.1099	15.4128	18.5111	17.2358
270021	17.1787	16.9457	18.0515	17.3782
270023	22.2639	22.7181	22.7162	22.5721
270026	17.5102	18.0568	20.1673	18.5919
270027	13.1392	17.2091	17.2005	15.5928
270028	21.1492	19.1177	19.6212	19.9204
270029	16.5666	17.3710	18.2097	17.3728
270032	17.7393	18.7811	19.3937	18.6694
270033	16.9602	18.4876	20.7060	18.6303
270035	16.8295	16.4302	17.9822	17.0833
270036	14.2537	16.8552	16.1031	15.5470
270039	15.9368	19.6796	20.3800	18.4120
270040	18.8145	20.1242	20.1887	19.6792
270041	19.0327	25.8153	*	21.5554
270044	16.7710	17.5137	19.2939	17.7721
270048	17.0154	18.0666	17.4506	17.4823
270049	22.2444	22.2540	22.0263	22.1740
270050	16.7110	19.9356	19.6317	18.7001
270051	20.2735	20.1950	20.0386	20.1652
270052	14.4773	14.7009	17.1932	15.3511
270057	21.1317	20.6714	20.1507	20.6215
270058	14.7481	16.1412	18.4780	16.2593
270059	14.7530	19.1808	16.9303	16.8245
270060	15.2727	20.4148	21.3776	18.5305
270063	12.6108	15.1049	16.4553	14.5559
270073	14.4569	16.1937	16.6083	15.6741
270079	15.6873	16.7048	19.5493	17.1331
270080	16.3171	15.0705	16.6010	15.9696
270081	15.6262	16.7389	18.0543	16.7908
270082	17.3443	23.1245	23.3209	21.2882
270083	18.4432	17.8554	16.8420	17.6939
270084	16.6243	16.2958	15.7062	16.1694
280001	17.3541	18.1831	18.7137	18.0270
280003	22.3179	23.0213	20.0498	21.6193
280005	19.2405	23.6949	20.1943	21.0207
280009	19.8145	20.9643	23.2300	21.3319
280010	17.4859	20.0462	*	18.1962
280011	15.8573	15.9614	16.2281	16.0212
280013	22.8063	22.5163	24.0852	23.1972
280014	15.9596	16.8368	16.7109	16.5080
280015	17.0281	16.6939	18.0207	17.2299

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
280017	14.2059	13.9939	16.9884	15.1266
280018	15.1328	15.4496	16.6439	15.7480
280020	19.9667	21.2467	21.9587	21.0976
280021	17.1048	17.6345	19.1263	17.9823
280022	16.7179	16.8184	15.3785	16.3083
280023	25.8494	22.3433	21.5761	23.0011
280024	14.2186	15.0380	15.8747	15.0019
280025	15.5850	21.4764	22.2214	19.5445
280026	16.6861	16.5851	18.7258	17.3359
280028	17.3176	18.0793	19.1080	18.1555
280029	23.1292	24.4359	17.1351	21.6012
280030	24.5366	24.7723	26.3542	25.1586
280031	13.5654	9.6321	9.6951	11.0351
280032	18.8964	19.1191	20.5246	19.5206
280033	15.7583	17.4745	17.9841	17.1215
280035	15.9170	16.6872	18.6089	16.9364
280037	16.7952	17.1064	14.8049	16.2282
280038	17.0878	18.2503	18.9305	18.0758
280039	16.0442	16.1587	17.0153	16.4148
280040	19.5333	20.9896	21.5426	20.7346
280041	16.4083	16.5503	16.6889	16.5558
280042	16.1191	16.6239	16.4684	16.3973
280043	16.6570	17.5937	16.8186	17.0314
280045	16.9048	15.7630	17.7408	16.7631
280046	17.9221	17.3214	17.9752	17.7358
280047	18.3407	17.4735	21.3143	18.9885
280048	15.8723	15.8100	17.9319	16.5389
280049	18.3605	18.4365	19.4589	18.7530
280050	16.6432	20.0379	*	18.4507
280051	15.6336	17.1942	19.6206	17.2054
280052	14.0819	14.1201	14.9903	14.4198
280054	18.7992	18.7575	19.4049	18.9732
280055	13.5667	13.8129	14.2046	13.8644
280056	12.6475	15.6135	15.6442	14.4971
280057	18.0454	20.0686	21.4754	19.8186
280058	19.6752	21.4868	22.8105	21.3952
280060	19.7527	20.7022	22.4677	20.9351
280061	17.1629	18.6370	20.2066	18.7084
280062	14.4896	15.6018	16.1708	15.4336
280064	16.2977	16.8330	18.2196	17.1053
280065	19.2932	20.7370	21.6999	20.6166
280066	11.6621	11.7207	12.2225	11.8688
280068	9.4943	10.5987	10.5103	10.1786
280070	17.7400	22.6201	18.7211	19.4766
280073	17.4244	17.7698	18.3496	17.8530
280074	16.4310	17.3143	13.6025	15.4955
280075	15.5327	13.2230	13.3154	13.8859
280076	14.8469	16.7488	16.1939	15.8857
280077	19.2068	20.0148	21.1883	20.1246
280079	10.4540	16.6117	17.1519	13.6519
280080	15.3308	16.9487	16.1902	16.1919
280081	21.0771	20.9606	23.3805	21.7809
280082	14.3399	14.6173	15.4420	14.8136
280083	18.2992	21.5336	20.8995	20.2370
280084	12.5836	13.6536	13.2158	13.1411
280085	20.4302	20.4825	20.8532	20.5742
280088	20.2961	*	*	20.2961
280089	18.1668	18.9567	19.9003	18.9565
280090	14.1362	15.1274	*	14.6858
280091	15.8436	16.1866	16.3456	16.1284
280092	14.1945	14.7912	13.3032	14.1038
280094	17.6873	16.3474	16.9180	16.9734
280097	14.1734	13.8223	14.1870	14.0603

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
280098	13.0029	12.5875	12.4995	12.6927
280101	13.5261	16.9973	10.5153	13.1647
280102	14.0102	*	*	14.0102
280104	13.2819	16.2167	15.5949	14.8930
280105	18.6575	21.0735	23.7103	21.1232
280106	16.1247	16.0679	16.3564	16.1791
280107	13.3311	14.4679	*	13.8480
280108	17.5625	17.1961	18.5134	17.7698
280109	12.6803	12.4408	*	12.5540
280110	12.7546	14.2136	13.0278	13.3282
280111	21.8773	19.6283	19.3508	20.2354
280114	15.7160	17.3076	17.1154	16.7114
280115	16.7041	18.1480	18.3464	17.7487
280117	17.7276	18.8279	20.3819	18.9864
280118	16.8687	18.6524	17.8891	17.8029
280123	14.0637	11.8582	23.6682	15.2035
280125	16.1332	16.3944	17.2718	16.5861
290001	22.8226	22.7450	24.1873	23.2686
290002	17.2554	16.5419	16.7948	16.8714
290003	22.8840	24.2175	24.4237	23.8452
290005	19.4888	21.9814	22.7804	21.4325
290006	21.8070	22.4063	19.9226	21.3745
290007	29.7706	30.9075	30.2824	30.3297
290008	20.6190	24.1255	26.9216	23.3785
290009	23.3620	23.9373	24.5919	23.9575
290010	15.6423	16.4476	20.8387	17.4968
290011	20.1564	21.1234	19.7410	20.3076
290012	21.8275	25.0430	25.3963	24.1843
290013	18.2713	15.7932	20.2914	17.8815
290014	18.9743	18.7829	20.2762	19.3806
290015	22.3487	19.4504	20.2336	20.6208
290016	14.3542	23.8656	21.8030	19.3661
290019	21.2509	22.2045	22.5584	22.0258
290020	20.8733	21.2380	19.5039	20.6806
290021	21.5806	22.9488	23.4950	22.6778
290022	24.5468	25.5011	24.8144	24.9547
290027	16.7786	13.3769	13.1463	14.2467
290032	22.8447	23.9504	26.8557	24.6837
290036	*	12.9074	*	12.9074
290038	20.6753	27.7030	26.0836	23.3519
290039	25.3864	25.5024	26.2466	25.7352
290041	*	25.9905	27.0613	26.6211
290042	*	18.7527	18.7669	18.7611
290043	*	27.9053	*	27.9053
300001	22.0909	23.8567	25.7142	23.9386
300003	22.9111	24.1297	25.3252	24.1024
300005	20.7545	22.2858	22.0518	21.6894
300006	23.7793	18.9745	22.2642	21.6739
300007	20.2372	20.6325	21.3633	20.7580
300008	20.7702	19.6149	20.9207	20.4237
300009	18.0602	20.0938	20.1193	19.3850
300010	19.3940	20.2130	21.0316	20.1973
300011	22.4325	23.0279	23.8390	23.0923
300012	24.5673	24.5619	25.8581	25.0347
300013	19.1247	20.1669	20.0983	19.8032
300014	20.3292	20.1774	21.6705	20.7353
300015	20.4916	19.6627	22.8966	21.0797
300016	21.8659	17.8148	15.1311	18.1853
300017	21.6563	22.7191	23.9651	22.8162
300018	21.2381	21.6385	22.9623	21.9864
300019	20.9753	19.6728	20.5801	20.4037
300020	21.9165	22.6627	23.0806	22.5724
300021	18.6211	19.3101	20.2585	19.4039

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
300022	18.3507	19.1875	20.1635	19.2197
300023	22.1210	22.7649	22.1896	22.3579
300024	19.9116	21.5842	22.2235	21.2127
300028	17.4075	20.0778	21.4207	19.6713
300029	22.5748	22.6013	23.8415	23.0427
300033	17.1869	17.1632	17.4836	17.2725
300034	25.5182	24.4975	25.2355	25.1020
310001	28.1329	27.4730	28.6540	28.0966
310002	28.3434	27.9728	28.5941	28.3065
310003	29.1096	27.5624	28.8314	28.5051
310005	22.1146	22.9712	22.9664	22.6779
310006	21.5957	22.0894	24.1538	22.5976
310008	23.5084	24.7618	26.4989	24.9206
310009	23.6371	21.7094	23.2420	22.8675
310010	22.5682	23.1060	24.5471	23.4312
310011	23.1977	24.2885	25.4900	24.3173
310012	26.5242	26.6772	28.0541	27.1062
310013	21.2251	22.5603	23.0073	22.2711
310014	27.4614	23.1956	31.0374	27.0132
310015	27.4331	27.9684	*	27.7058
310016	24.3838	24.5206	25.4844	24.7602
310017	25.7902	24.5976	25.1634	25.1866
310018	22.8428	22.4779	24.1496	23.1662
310019	24.0542	24.9914	28.5952	25.8565
310020	24.1848	24.4152	25.0803	24.5523
310021	23.9369	25.4393	29.9117	26.2679
310022	21.2706	20.8258	21.2563	21.1130
310024	24.2353	24.9521	27.2475	25.4630
310025	24.3513	24.1812	25.5227	24.6926
310026	23.5491	22.1997	23.2895	22.9937
310027	21.8846	22.5696	24.4437	22.9152
310028	23.4577	23.9428	26.1931	24.5392
310029	22.6629	23.6610	25.2587	23.8421
310031	26.1567	26.6831	26.7174	26.5090
310032	24.3528	24.7404	25.4768	24.8830
310034	23.2729	24.1150	27.1303	24.7884
310036	20.1905	21.7187	23.0320	21.6137
310037	27.7823	28.1289	29.0864	28.3334
310038	26.7209	28.4893	28.4732	27.9039
310039	22.1754	22.7317	23.6605	22.8221
310040	26.1492	26.3573	26.5964	26.3696
310041	24.8960	23.5559	24.9733	24.4816
310042	23.2472	24.7678	25.7747	24.5600
310043	21.9022	21.6128	24.0238	22.3478
310044	21.6677	23.1549	23.3801	22.7473
310045	28.4854	28.9274	29.5452	28.9708
310047	25.1101	26.1921	25.9777	25.7489
310048	23.6118	25.2870	23.4189	24.0965
310049	24.8299	27.0842	25.6732	25.8686
310050	25.1752	24.7988	23.7735	24.5800
310051	27.1265	27.5378	28.5946	27.7258
310052	22.9326	23.3973	27.0616	24.3173
310054	26.1726	27.7376	26.9352	26.9153
310057	21.1686	22.2572	22.2630	21.9057
310058	26.5308	26.3765	25.9389	26.3360
310060	19.1992	20.0997	21.6211	20.2716
310061	23.2646	33.9582	23.4283	26.0987
310062	22.9073	*	*	22.9073
310063	21.9045	22.1080	23.5217	22.4712
310064	24.8567	25.4822	25.3339	25.2160
310067	25.0888	23.9278	24.1943	24.4277
310069	23.7531	24.2329	25.4373	24.4865
310070	26.0903	28.2220	30.1143	28.0038

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
310072	21.7605	22.5611	25.0708	23.0824
310073	28.5149	26.2937	29.2805	27.9813
310074	23.8340	22.3588	24.1313	23.4934
310075	23.3266	24.4788	23.9771	23.9276
310076	30.0797	27.9918	31.4866	29.8824
310077	25.2500	26.1251	26.7227	26.0109
310078	23.8841	24.0587	24.5862	24.1519
310081	22.0762	22.4086	23.2059	22.5650
310083	23.8852	24.8204	25.0191	24.5773
310084	26.6753	24.6049	25.5110	25.5914
310086	22.1674	23.1719	23.5820	22.9629
310087	20.7243	21.1215	20.7434	20.8650
310088	22.3160	23.1722	24.2150	23.2258
310090	23.8284	24.8986	24.4746	24.3899
310091	22.7978	23.2969	24.5357	23.5110
310092	20.5165	21.6964	23.1341	21.7772
310093	22.4291	23.7251	24.0037	23.3380
310096	25.1572	24.5759	26.6982	25.4341
310105	25.5891	26.2537	25.1559	25.6770
310108	22.4756	23.8308	26.2036	24.1336
310110	21.8341	23.2146	23.1789	22.7903
310111	21.1066	22.1151	24.1731	22.4723
310112	23.6701	24.7914	24.2999	24.2528
310113	23.6841	23.1961	24.0930	23.6671
310115	21.7320	21.1645	23.4249	22.1167
310116	22.9812	23.6366	*	23.3055
310118	26.4625	26.1315	26.5619	26.3869
310119	33.6686	32.7858	29.1045	31.7976
310120	23.9681	23.3200	22.6526	23.3189
320001	19.1150	20.6225	21.0689	20.2496
320002	22.6175	23.0983	25.5144	23.6846
320003	15.9504	16.4642	16.4961	16.3037
320004	18.5824	19.6642	21.3681	19.9888
320005	21.6103	21.0411	22.4178	21.7283
320006	18.9019	20.3863	19.8672	19.6917
320009	18.2883	19.3500	20.3783	19.2661
320011	20.0601	18.5222	18.7099	19.0944
320012	16.4355	17.1764	14.3961	16.0417
320013	22.9573	24.5543	24.4795	24.0591
320014	16.3598	16.8412	21.7784	18.0981
320016	20.5398	18.8519	18.8763	19.4121
320017	18.6388	19.4498	20.4390	19.4898
320018	18.8479	19.2336	20.4375	19.5136
320019	24.4707	26.9637	24.4394	25.3985
320021	17.8705	19.1265	19.6950	18.8702
320022	16.1777	18.0606	19.9587	18.1477
320023	18.0548	17.8419	*	17.9685
320030	16.5495	18.6859	18.1556	17.7555
320031	19.6768	25.1715	18.2244	20.7137
320032	18.8097	20.6871	21.1628	20.1426
320033	25.0777	21.0621	21.9804	22.5777
320035	21.5186	15.0612	17.8058	17.7193
320037	17.0305	17.8280	17.6619	17.5121
320038	16.8117	22.2664	*	19.6948
320046	18.3190	18.9607	22.6251	20.0803
320048	19.9642	16.8769	*	18.3467
320063	18.3237	17.9089	14.4611	17.0236
320065	16.7933	18.6525	22.1138	18.8982
320067	33.8654	15.3228	16.8015	18.3132
320068	17.4785	18.5103	15.6681	17.1335
320069	13.0094	14.4212	15.7350	14.3622
320074	19.3406	20.2290	22.3403	20.2679
320079	18.2828	19.8555	19.9049	19.3010

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
330001	26.5533	27.3996	28.4974	27.5189
330002	26.5370	26.9341	26.6966	26.7185
330003	19.4102	18.9211	19.3972	19.2414
330004	22.5298	20.9501	22.5082	22.0002
330005	24.8338	22.1957	22.6137	22.8232
330006	25.0576	25.8006	26.2970	25.7013
330007	18.9024	*	*	18.9024
330008	19.0045	19.2341	19.6770	19.3060
330009	30.6918	31.3435	30.9087	30.9793
330010	17.4512	16.6508	17.8935	17.3146
330011	18.2986	18.6748	18.7995	18.5936
330012	32.7624	*	*	32.7624
330013	19.0856	19.6269	19.0995	19.2697
330014	32.3370	36.8669	32.4496	33.8020
330016	16.9717	16.8016	18.7194	17.4483
330019	35.9822	33.5369	31.5927	33.4812
330020	15.5527	15.1142	16.6952	15.7780
330023	24.4006	25.6512	26.6997	25.5866
330024	34.1682	37.3316	35.7485	35.6717
330025	16.2033	16.8687	17.6169	16.8903
330027	33.4738	35.5255	35.1046	34.6601
330028	28.2089	29.5294	31.7699	29.9762
330029	18.1567	17.0016	19.4377	18.2068
330030	17.4977	19.1085	18.0866	18.1511
330033	18.5353	17.4444	19.4402	18.4646
330034	31.3997	27.7738	38.2451	31.3373
330036	23.9874	25.2820	25.5888	24.9782
330037	16.1140	16.4866	18.3260	16.9831
330038	16.2549	17.3429	16.2997	16.6434
330041	24.5215	31.4871	29.5305	28.1630
330043	28.7467	27.4661	28.9622	28.3990
330044	20.0238	19.5219	19.9808	19.8437
330045	28.0758	27.9919	28.5267	28.2011
330046	32.4189	35.2703	38.1184	35.1742
330047	18.1815	18.5536	19.5561	18.7655
330048	17.8787	19.1093	19.6129	18.8634
330049	19.4993	20.5731	22.1523	20.7576
330053	17.4430	17.8082	17.8308	17.6930
330055	36.1109	32.8910	32.6387	33.8113
330056	30.4525	30.0945	29.8377	30.1337
330057	18.7478	19.3643	20.0995	19.4010
330058	17.0014	17.7672	18.1007	17.6091
330059	34.1705	34.2426	35.0121	34.4519
330061	25.7331	25.4082	26.8580	25.9786
330062	17.6067	18.1318	18.4662	18.0774
330064	33.1269	33.6447	35.1422	33.9496
330065	19.8940	19.9305	20.2835	20.0284
330066	19.5611	18.8707	19.5272	19.3115
330067	20.9443	22.1065	23.6836	22.2657
330072	30.8019	30.4171	30.3737	30.5362
330073	16.2898	16.4518	16.5166	16.4181
330074	18.0005	17.7308	18.7081	18.1472
330075	17.2298	17.6385	18.9699	17.9293
330078	16.7949	18.7884	18.0362	17.8405
330079	17.4555	18.7622	18.9398	18.3917
330080	29.2686	31.4424	28.3401	29.6840
330084	18.0435	19.3216	19.0261	18.8002
330085	20.2926	20.6203	22.8312	21.2658
330086	31.2980	23.6496	26.2979	27.1579
330088	25.6626	25.7940	26.7583	26.0739
330090	19.3954	19.2112	20.4314	19.6779
330091	19.0953	19.7776	21.6004	20.1526
330092	14.0671	13.3723	17.2083	14.8861

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
330094	17.5585	18.1582	18.7259	18.1488
330095	20.1073	21.1096	21.1809	20.7563
330096	17.9641	18.5149	20.0370	18.8403
330097	16.2169	16.4433	15.8232	16.1519
330100	27.0661	29.0916	28.9956	28.3021
330101	32.4105	31.5914	34.7119	32.9505
330102	17.5755	19.0058	21.0057	19.0881
330103	15.7197	16.8110	17.8864	16.8159
330104	31.6471	31.2074	31.9154	31.5867
330106	40.2686	35.3775	35.1434	36.7949
330107	28.5580	27.7797	28.9225	28.4199
330108	17.3605	18.0786	18.5194	17.9737
330111	19.5314	15.9321	13.3352	15.9787
330114	17.3522	17.0581	19.1162	17.8316
330115	17.4430	17.4684	13.0722	15.4701
330116	24.4622	14.9610	16.8567	18.1237
330118	20.6936	*	*	20.6936
330119	34.8385	33.1179	33.5653	33.8391
330121	16.1052	16.3385	17.1869	16.5359
330122	20.8204	20.2417	23.0384	21.3559
330125	19.8494	19.7638	20.3093	19.9745
330126	23.7938	23.8957	24.8787	24.2123
330127	31.9046	30.7356	33.9627	32.2469
330128	29.0222	30.8242	27.7350	29.2603
330132	15.7633	14.3673	14.8704	15.0313
330133	37.2494	35.3576	37.5192	36.5906
330135	18.7120	22.2670	23.5662	21.3289
330136	18.2422	20.1043	20.0552	19.4517
330140	19.1438	19.3615	20.2951	19.5989
330141	26.4956	26.7096	27.5960	26.9363
330144	14.0566	16.2517	17.1513	15.7880
330148	16.8151	16.2782	16.7251	16.6024
330151	16.0714	15.7594	15.2233	15.6663
330152	30.5409	30.8314	33.4288	31.5069
330153	18.9689	18.1776	19.4417	18.8671
330157	22.0792	22.3804	23.1743	22.5628
330158	25.7569	27.1228	29.3163	27.3406
330159	19.1536	19.4998	20.2601	19.6219
330160	32.7840	29.5885	30.7893	30.9997
330162	27.1166	27.6010	27.9705	27.5570
330163	18.7816	20.7456	21.4143	20.2444
330164	19.8647	20.9003	20.5006	20.4195
330166	15.0954	15.4420	17.0637	15.8309
330167	29.3634	30.2346	32.0728	30.4495
330169	37.2655	35.4794	36.3690	36.3400
330171	25.5307	24.8035	24.8515	25.0649
330175	17.3290	18.3116	18.8201	18.1260
330177	17.2907	16.3704	16.6059	16.7542
330179	13.4999	13.8953	15.8620	14.3577
330180	16.8787	17.9877	19.2670	17.9995
330181	32.5192	33.0908	34.2919	33.2777
330182	32.9371	33.6531	33.3363	33.3137
330183	19.9207	20.6164	19.6980	20.0807
330184	30.0400	31.3706	28.4726	30.0103
330185	25.6112	26.8612	27.8585	26.7622
330188	20.9587	18.8000	20.2849	20.0186
330189	15.1253	18.4498	23.5589	18.7634
330191	18.6206	19.0348	19.4168	19.0266
330193	36.5481	30.2260	32.5496	32.9872
330194	34.6785	35.2036	35.6486	35.1819
330195	33.3254	34.8966	29.8157	32.7136
330196	30.8165	30.5799	25.9671	29.2151
330197	17.6646	18.3527	19.2237	18.4045

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
330198	24.6038	24.8590	25.4472	24.9692
330199	28.7609	30.5409	26.0228	28.5436
330201	32.1149	28.7861	27.6320	29.6019
330202	31.4435	31.2575	31.9777	31.5574
330203	20.7575	25.0345	25.7916	23.7288
330204	29.4418	32.2005	28.4140	30.0233
330205	20.5793	22.3490	24.9040	22.5611
330208	26.1822	26.6682	27.3170	26.7219
330209	23.9924	25.1281	26.8546	25.3803
330211	19.5064	19.5405	20.0006	19.6855
330212	21.7705	24.7681	24.4902	23.6390
330213	18.7722	19.6796	20.1166	19.4878
330214	36.4447	32.4292	32.2640	33.3003
330215	19.6926	17.9863	19.0726	18.8818
330218	21.4796	21.1890	21.4747	21.3812
330219	23.9908	23.4310	25.1792	24.1748
330221	27.8485	33.3796	29.5535	30.2856
330222	18.3666	18.5571	19.3148	18.7515
330223	17.6199	17.8306	19.0773	18.1866
330224	19.6410	20.4309	20.7773	20.2793
330225	25.5823	27.0379	28.0523	26.7760
330226	16.6711	23.1859	16.9198	18.3930
330229	16.8026	17.5326	18.2554	17.5103
330230	29.7626	29.6283	30.6937	29.9984
330231	30.0923	32.7200	25.2793	29.5345
330232	17.9083	19.1787	19.6181	18.8942
330233	30.9241	44.1265	42.3510	37.9819
330234	35.1777	35.0720	35.8927	35.3813
330235	21.0842	19.5880	20.1255	20.2820
330236	29.5913	31.3463	30.9816	30.6263
330238	15.6245	17.3976	17.5807	16.8401
330239	17.4462	18.5079	18.9953	18.2764
330240	29.7082	30.7321	32.0049	30.7179
330241	24.6076	23.8638	24.7545	24.4065
330242	28.2612	27.6384	28.3561	28.0883
330245	17.6767	18.5161	20.7167	19.0400
330246	28.1090	28.1205	29.8777	28.6473
330247	28.5310	27.3937	32.5858	29.3555
330249	16.2687	17.1320	17.6846	17.0482
330250	19.5823	19.9619	20.7381	20.1092
330254	18.4057	15.9123	15.7864	16.7695
330258	29.7426	31.8910	32.6745	31.4411
330259	26.2661	25.9994	26.3620	26.2118
330261	25.7244	27.9766	30.0489	27.8583
330263	20.4149	18.7378	19.5057	19.6112
330264	22.8672	22.8099	24.6387	23.4672
330265	18.0193	17.6301	21.1215	18.8985
330267	24.5183	24.5939	27.8255	25.6678
330268	13.0595	15.9060	16.8358	15.2987
330270	34.4254	36.0824	31.3908	33.9198
330273	23.1511	26.0565	27.0454	25.3482
330275	19.0548	18.7268	*	18.9109
330276	18.2870	19.0228	19.2611	18.8572
330277	18.3169	19.1761	20.7851	19.4340
330279	19.5983	20.7107	21.7827	20.6371
330285	23.5264	24.0491	25.9154	24.4664
330286	26.7633	27.7762	28.0994	27.5677
330290	33.5056	30.4706	34.3439	32.7503
330293	16.2158	16.9238	17.2262	16.7522
330304	26.7683	27.3562	29.2207	27.7999
330306	27.3798	29.5937	25.6970	27.5466
330307	21.0673	21.7257	23.1148	21.9912
330314	24.5444	25.9937	25.5405	25.3155

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
330316	27.6102	27.9543	27.9277	27.8310
330327	16.4611	20.3874	20.1705	18.8688
330331	31.6216	33.1276	31.0718	31.9586
330332	27.6914	25.3689	27.6955	26.9473
330333	29.1931	*	28.8841	29.0179
330336	29.7689	29.8294	29.1415	29.5860
330338	22.4581	21.2670	23.6142	22.4472
330339	20.0111	20.1028	20.2382	20.1121
330340	28.8419	28.4129	29.4512	28.8934
330350	30.8889	30.9763	33.5493	31.7771
330353	32.1984	34.2431	34.2260	33.5106
330357	36.5928	34.1846	36.8598	35.8981
330372	28.8482	33.3771	27.8854	29.8144
330381	31.0091	31.8602	*	31.4219
330385	35.6722	33.2246	33.4159	34.1965
330386	17.6383	20.4231	21.4363	19.4104
330389	30.2505	37.3749	27.6223	31.1985
330390	31.1577	30.8744	33.4372	31.7841
330393	26.4958	27.8352	33.6061	29.1012
330394	19.2392	18.9343	19.6892	19.2847
330395	32.8749	32.7494	30.2846	32.0161
330396	34.8648	30.7961	29.1753	31.7581
330397	33.9061	32.6068	38.3281	34.7790
330398	28.7707	29.2872	*	28.9084
330399	32.9100	33.3012	32.7149	32.9707
330400	*	16.2707	16.8168	16.5566
340001	18.1814	19.7093	21.8572	19.9040
340002	20.8858	20.5253	22.2638	21.3163
340003	20.2540	19.5145	19.6545	19.8018
340004	19.0695	20.9863	23.0890	21.0811
340005	15.8205	16.7176	16.3073	16.2815
340006	16.9818	16.5709	16.1379	16.5756
340007	17.2356	18.3399	18.3760	17.9959
340008	21.2889	20.4157	22.0774	21.2828
340009	20.5023	20.9178	20.6155	20.6734
340010	18.3380	19.4302	20.6547	19.5049
340011	13.6554	14.4798	17.4534	15.1697
340012	18.8701	17.5112	19.3651	18.5479
340013	20.1747	19.4613	21.5130	20.3981
340014	20.5748	27.7888	21.9804	22.9126
340015	20.1562	19.4676	20.3493	19.9875
340016	17.5404	18.8958	19.4160	18.6049
340017	19.4192	20.2775	20.6263	20.1119
340018	14.0930	18.1751	16.4611	16.0927
340019	14.8980	15.2887	15.9037	15.3369
340020	18.6334	18.0897	19.2392	18.6598
340021	19.8020	20.5813	22.0220	20.7507
340022	17.8178	18.7714	20.6484	19.0742
340023	18.5414	19.3146	19.2617	19.0575
340024	17.3824	17.9130	19.1430	18.1515
340025	17.2648	18.4628	19.1770	18.3029
340027	18.0816	19.4548	19.4907	19.0172
340028	18.4787	19.9403	20.6496	19.7560
340030	21.1420	22.4709	24.0238	22.4825
340031	14.6951	14.6370	15.4935	14.9011
340032	20.0049	20.7444	21.7127	20.8112
340035	20.2312	18.9930	18.5883	19.2823
340036	18.2190	17.7619	18.4203	18.1226
340037	16.6576	17.5829	18.3655	17.5271
340038	17.3762	18.1493	20.3091	18.5547
340039	20.5876	21.3711	22.2939	21.4440
340040	20.4282	20.7237	21.1020	20.7582
340041	15.1419	15.5873	16.3200	15.6803

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
340042	16.9298	17.0034	19.1386	17.6977
340044	18.8687	18.0863	18.9562	18.6425
340045	13.0538	13.6182	20.2641	14.9554
340047	20.0602	20.0744	20.7061	20.2776
340049	19.2050	19.5127	17.2986	18.6550
340050	20.0090	19.6726	20.6831	20.1383
340051	16.5617	19.3627	19.0282	18.2702
340052	22.8173	23.2134	26.2243	23.8462
340053	20.9495	19.9915	22.6020	21.1247
340054	15.5993	15.5090	16.6208	15.8560
340055	19.6056	19.4035	20.2936	19.7761
340060	18.7137	19.3410	20.8570	19.6422
340061	21.5385	22.1175	23.7173	22.4390
340063	17.0249	16.7377	26.4132	19.5650
340064	20.7125	18.5069	17.7395	18.9394
340065	17.5414	17.3530	18.3610	17.7341
340067	19.3785	19.7187	22.4054	20.2943
340068	16.6305	17.8065	18.8758	17.7729
340069	21.0840	21.6728	22.5664	21.7942
340070	19.7796	20.6829	21.5793	20.6882
340071	17.1424	18.0767	19.3679	18.2275
340072	16.7400	17.7129	18.7920	17.7544
340073	21.9761	23.5832	23.4906	23.0367
340075	18.7090	20.0081	19.9451	19.5511
340080	22.2533	18.2061	*	20.1809
340084	17.1532	19.0103	19.6087	18.5190
340085	17.3462	18.3179	20.3684	18.6708
340087	17.3884	18.2255	20.2445	18.6743
340088	21.0226	22.2322	22.6462	21.9702
340089	13.8535	15.4760	16.1321	15.1566
340090	17.0584	18.5287	18.7701	18.1576
340091	20.5923	20.3861	21.1892	20.7475
340093	16.3276	16.8903	16.5452	16.5873
340094	19.0406	*	20.8816	19.9881
340096	17.8189	19.4696	20.9686	19.4268
340097	18.8412	18.2399	20.0302	19.0440
340098	21.4135	21.9578	23.5280	22.3354
340099	16.8305	15.3752	16.9979	16.3421
340101	13.9994	15.6509	20.7841	16.3562
340104	13.0462	11.5169	12.1845	12.2454
340105	20.2954	*	*	20.2954
340106	17.7220	18.1211	19.1147	18.3112
340107	18.0205	19.3197	20.7601	19.3267
340109	18.7746	19.0532	19.3357	19.0640
340111	16.3344	16.5976	17.2127	16.7260
340112	14.7562	15.5142	16.9592	15.7587
340113	21.2906	21.9883	24.0277	22.4262
340114	21.2166	20.7261	21.7750	21.2327
340115	19.7578	21.7586	24.7924	21.8733
340116	20.4255	20.6800	21.6616	20.9285
340119	18.8507	19.5827	20.5394	19.6919
340120	15.0410	15.8240	16.9847	15.9742
340121	16.3295	17.8771	19.0420	17.7638
340123	16.9114	18.9078	21.5041	19.1720
340124	15.5779	17.4185	17.5411	16.8707
340125	19.7164	20.2748	*	19.9923
340126	18.8100	19.3734	20.7395	19.6489
340127	19.3925	19.3842	21.4797	20.0982
340129	20.4605	20.6521	21.0773	20.7569
340130	19.7422	19.8707	20.5851	20.0891
340131	19.7908	21.3849	23.2478	21.4650
340132	17.3448	17.5711	17.7110	17.5495
340133	16.4766	17.2138	16.9829	16.8955

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
340137	21.0249	31.7702	*	23.8273
340138	20.7618	*	*	20.7618
340141	21.3754	21.4986	22.4525	21.7877
340142	17.1525	18.0766	18.1824	17.8038
340143	21.3604	24.4098	21.9304	22.5287
340144	20.9113	22.9183	22.8634	22.2296
340145	20.1081	19.9233	21.5958	20.6005
340146	15.9203	17.3051	19.1306	17.3989
340147	19.6827	20.5520	21.5912	20.6397
340148	18.5875	18.9912	20.6790	19.3782
340151	16.7275	18.4733	19.0779	18.0943
340153	20.6420	20.7533	21.7375	21.0743
340155	20.5792	23.1021	24.8963	22.8382
340158	18.1439	19.0843	20.0921	19.1509
340159	17.3893	19.0338	18.3028	18.2386
340160	16.1778	16.7170	17.1963	16.7262
340162	14.3472	*	*	14.3472
340164	21.2523	21.5769	*	21.4120
340166	20.0434	20.8270	22.0519	21.0278
340168	15.2919	15.6071	15.4250	15.4443
340171	21.5973	22.4779	22.7304	22.3095
340173	19.3353	21.0898	23.3690	21.3475
350001	14.9080	16.6551	15.6193	15.7235
350002	17.5259	18.3459	19.1931	18.3399
350003	18.2470	19.2840	20.0663	19.1912
350004	20.6518	23.7016	25.1976	23.1394
350005	18.3792	19.9156	20.7467	19.6757
350006	18.4107	19.0343	19.1257	18.8317
350007	13.3292	13.8824	13.9966	13.7234
350008	20.4777	22.3783	23.1361	21.9692
350009	19.1611	18.3688	19.3668	18.9603
350010	16.2808	16.6272	16.7774	16.5574
350011	18.2008	19.1944	20.6809	19.2312
350012	15.7033	18.2524	16.0990	16.7533
350013	16.4579	17.2596	17.5935	17.0893
350014	16.8403	18.0999	18.2003	17.6546
350015	16.3397	17.1071	16.5368	16.6512
350016	11.6524	*	*	11.6524
350017	17.6278	17.5124	18.0840	17.7360
350018	14.4928	16.4939	16.3210	15.7222
350019	19.3063	20.1608	20.6743	20.0169
350021	16.2898	17.7123	16.3394	16.7592
350023	17.9048	17.4983	18.3253	17.9187
350024	14.7529	15.4788	15.7510	15.3010
350025	17.1199	15.0469	14.6099	15.5234
350027	15.0835	15.5178	17.5882	15.9431
350029	13.5219	14.6173	*	14.0747
350030	17.7209	18.1131	18.7182	18.1761
350033	14.9012	16.0870	16.0903	15.6588
350034	18.7245	19.6445	*	19.1773
350035	10.4570	11.7675	12.6496	11.6111
350038	17.6666	19.6854	19.0500	18.7554
350039	17.0361	16.6278	14.8599	16.1842
350041	14.6680	19.1341	23.1150	18.5427
350042	16.7402	19.3309	19.3370	18.2440
350043	16.8876	16.7433	17.6722	17.1008
350044	10.2154	11.0601	10.9690	10.7163
350047	14.4628	18.0094	19.9749	17.4882
350049	14.8019	18.1993	16.7131	16.4253
350050	11.4921	12.2183	*	11.8525
350051	17.7279	17.0653	16.4587	17.0939
350053	14.6398	15.9160	16.5484	15.6473
350055	14.5691	15.7916	15.8572	15.3943

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
350056	14.8293	15.0995	15.7752	15.2147
350058	15.9378	16.7034	15.8171	16.1663
350060	10.3666	10.3076	10.5325	10.3988
350061	15.7269	18.8790	19.3748	18.0353
360001	17.0791	19.6655	18.5766	18.4186
360002	18.0139	18.2613	19.6145	18.5918
360003	22.7471	22.7521	23.2905	22.9196
360006	21.8048	22.4436	22.8554	22.3622
360007	18.0941	14.8213	15.3656	16.0665
360008	18.5439	18.7961	19.8034	19.0500
360009	18.9322	18.9935	19.6087	19.1932
360010	19.2288	19.1852	20.4671	19.6517
360011	19.3835	21.3659	19.4581	19.9957
360012	19.9881	20.0525	21.8759	20.5910
360013	20.6021	21.3690	22.3407	21.4314
360014	20.2390	20.7419	22.9930	21.3333
360016	17.8065	21.2505	21.4202	20.0256
360017	21.7543	22.2740	22.6535	22.2073
360018	23.5219	24.6686	24.6694	24.2429
360019	18.7147	20.6480	21.4708	20.1693
360020	21.7806	22.1751	21.7288	21.8938
360024	19.8508	20.1352	20.9408	20.3040
360025	20.3638	20.2531	20.9266	20.5175
360026	18.2222	17.9523	18.6739	18.2838
360027	21.0406	21.7650	22.6915	21.8330
360028	17.0177	18.7174	*	17.7935
360029	18.7622	19.2928	19.7246	19.2680
360030	17.5748	17.6058	19.0313	18.0839
360031	19.3858	21.0687	21.0481	20.5037
360032	18.6559	19.8020	19.8367	19.4058
360034	14.9534	17.9594	19.1248	17.3380
360035	20.5557	21.0674	21.0533	20.8877
360036	20.2107	20.9916	21.4665	20.8874
360037	23.5094	23.1674	23.8620	23.5454
360038	21.2467	19.9415	20.9651	20.7274
360039	18.7791	19.0013	19.1934	18.9931
360040	18.1618	18.7425	19.9750	18.9827
360041	19.5744	19.7968	21.2727	20.2776
360042	17.4306	17.1952	19.3774	17.9518
360044	17.0612	17.6882	17.8417	17.5521
360045	22.1471	22.4018	22.8112	22.4244
360046	20.4755	20.4607	21.4292	20.8030
360047	17.1871	15.2922	15.8279	16.0315
360048	22.5857	22.4890	25.6259	23.4295
360049	20.4564	20.8393	*	20.6400
360050	12.9873	15.0568	15.6847	14.5392
360051	20.8338	20.8757	21.2225	20.9792
360052	19.6233	18.7931	19.8278	19.4110
360054	17.2574	17.4911	17.5714	17.4428
360055	21.5585	21.4112	22.8755	21.9415
360056	19.0474	20.6968	23.2385	21.0356
360057	15.0146	15.8569	16.0395	15.6552
360058	18.6992	19.3306	19.0440	19.0197
360059	20.5618	19.9304	23.2129	21.1909
360062	20.7588	21.9195	24.4898	22.4391
360063	18.4512	17.5108	20.2671	18.6964
360064	20.4846	20.0615	20.9202	20.4850
360065	20.0532	19.6199	22.0853	20.5895
360066	21.6015	22.8175	23.8834	22.7933
360067	15.3157	14.2745	17.3024	15.5854
360068	21.2789	22.6227	22.2094	22.0456
360069	16.6982	14.6597	18.5382	16.4901
360070	17.3758	18.8406	19.4700	18.5552

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
360071	17.9756	19.0302	19.6873	18.9152
360072	18.1467	19.0166	20.8819	19.3874
360074	20.8275	18.5889	19.9876	19.7904
360075	22.4523	26.0663	27.6992	24.6791
360076	20.0700	20.3317	21.0402	20.4919
360077	21.1053	21.5517	22.2964	21.6371
360078	21.4392	22.6490	22.6075	22.2329
360079	22.1096	21.6644	23.9491	22.5122
360080	17.3892	17.6369	18.0392	17.6871
360081	21.7342	20.4614	20.7477	20.9963
360082	22.9460	20.7610	22.9390	22.1817
360084	20.4894	22.0492	22.1699	21.5674
360085	21.9051	21.5151	24.8010	22.5708
360086	19.5378	19.3701	20.5858	19.8561
360087	20.1684	20.7969	21.1621	20.7100
360088	24.0097	24.0822	20.5703	22.7567
360089	18.3881	18.1941	19.5260	18.6947
360090	21.0376	20.8971	21.2072	21.0517
360091	21.3126	21.8447	22.6510	21.9522
360092	20.4534	21.5073	20.9588	20.9684
360093	19.3292	19.0261	21.0134	19.7919
360094	18.8780	20.1227	21.1952	20.0119
360095	20.4149	19.8521	21.3505	20.5395
360096	18.2215	19.6726	20.9838	19.6144
360098	19.5314	19.8178	20.7942	20.0486
360099	18.5855	19.6241	20.8801	19.7171
360100	17.8989	18.0442	20.0683	18.5932
360101	21.3914	20.2635	24.1551	21.8064
360102	19.4345	18.5367	*	19.0252
360106	18.9752	19.1778	18.9779	19.0463
360107	19.7599	22.1359	*	20.9636
360108	17.5832	20.0681	19.0870	18.9015
360109	20.1032	19.9237	17.3564	18.9331
360112	22.5589	24.6335	25.7920	24.1917
360113	24.2654	20.8154	18.4832	21.0469
360114	17.8761	18.7509	19.4212	18.7051
360115	18.8059	20.7652	21.0104	20.2115
360116	18.8882	18.8319	20.1408	19.2675
360118	19.3732	19.9141	21.0235	20.1425
360121	22.1093	22.2175	21.9111	22.0788
360123	20.3236	20.9792	21.9985	21.1330
360125	19.0774	20.5508	21.6675	20.3325
360126	19.0036	24.5387	*	21.4419
360127	17.5882	16.5559	18.2150	17.4610
360128	16.1243	17.0515	17.5495	16.8959
360129	15.5002	16.6114	17.2309	16.4330
360130	17.2009	18.4539	19.8906	18.4639
360131	19.2241	18.4688	20.4123	19.3509
360132	19.9171	21.3493	21.0162	20.7647
360133	19.4316	20.2857	22.1957	20.5231
360134	20.6876	20.9564	21.4024	21.0100
360136	17.7827	18.2194	18.5687	18.1837
360137	20.1756	22.3648	23.1642	21.8556
360140	20.2791	21.2881	18.3463	19.9463
360141	23.0016	23.5343	23.5006	23.3475
360142	17.0059	18.3188	19.6189	18.3226
360143	20.1989	21.0336	20.9158	20.7118
360144	23.2191	20.9033	20.9386	21.6583
360145	19.6413	20.0513	21.2931	20.3252
360147	16.6616	17.6779	18.7258	17.7129
360148	19.2816	19.1393	20.3120	19.5918
360149	19.9808	*	*	19.9808
360150	21.1327	22.3620	23.1858	22.2110

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
360151	16.6019	19.2788	20.5594	18.6756
360152	20.8328	21.6005	20.8782	21.1044
360153	15.4132	16.7399	16.1021	16.0822
360154	14.3270	14.3593	14.8550	14.5038
360155	22.5347	22.2112	22.2805	22.3386
360156	17.8787	18.9095	19.9382	18.8811
360159	20.2841	21.5695	22.7992	21.5782
360161	19.1983	20.6160	19.9054	19.9030
360163	20.7275	21.2689	22.1012	21.3886
360165	18.2571	18.2417	19.6205	18.6959
360166	18.7321	*	*	18.7321
360170	16.4653	20.4407	19.3099	18.5975
360172	18.6720	19.8909	22.3294	20.3872
360174	19.9725	20.5399	20.5874	20.4239
360175	21.1685	21.5450	22.0274	21.5958
360176	15.9430	16.6228	17.6291	16.7269
360177	18.7898	18.9576	19.6992	19.1509
360178	18.8704	16.7962	18.0773	17.9514
360179	21.1309	20.7069	21.9617	21.2476
360180	21.3826	21.0146	18.0143	20.0375
360184	19.1224	*	*	19.1224
360185	18.7291	19.4858	20.0848	19.4376
360186	18.3246	20.7572	18.1254	19.0367
360187	18.5109	19.6535	20.8423	19.6414
360188	17.1044	18.3057	16.4329	17.3292
360189	17.8981	18.5940	19.0481	18.4968
360192	21.6365	22.7846	23.9969	22.7928
360194	17.1884	17.6140	19.3901	18.0653
360195	19.9302	20.5828	21.2083	20.5836
360197	20.0603	20.5062	21.6110	20.7240
360200	16.2306	17.9623	19.5866	17.8050
360203	16.3181	15.9609	17.9698	16.7236
360204	22.2494	*	*	22.2494
360210	20.9955	21.8629	21.5961	21.4839
360211	19.9895	20.6081	22.0011	20.8512
360212	21.1123	20.6987	21.0632	20.9556
360213	19.4765	19.0584	20.5448	19.6749
360218	18.9469	18.8204	20.7709	19.5181
360230	21.9763	20.8042	21.2417	21.3193
360231	12.9588	14.4168	12.7388	13.3090
360234	23.2588	20.6131	17.6716	20.3070
360236	17.8426	21.4628	20.5998	19.8666
360239	20.1854	19.2375	20.9440	20.0997
360241	23.5318	25.3741	23.7679	24.1749
360243	14.8694	*	*	14.8694
360245	16.4622	15.9782	16.7956	16.4127
360247	16.3092	17.0776	*	16.6743
360249	*	25.4331	*	25.4331
360251	*	*	21.3149	21.3149
360252	*	*	27.1728	27.1728
370001	22.5214	24.1929	21.8743	22.8253
370002	14.7315	15.4333	16.1853	15.4106
370004	19.3236	18.5233	22.0173	19.9087
370005	15.1654	15.3881	*	15.2760
370006	16.6484	16.4995	15.7367	16.2765
370007	15.2905	15.8312	14.4961	15.2449
370008	16.6566	17.5553	18.5253	17.5877
370011	14.9701	15.6178	16.1757	15.5584
370012	11.7265	12.4942	13.3824	12.5268
370013	19.3398	18.9584	19.3237	19.2083
370014	20.6512	20.2858	22.7976	21.2589
370015	17.0319	20.8765	18.6446	18.7763
370016	19.1191	19.1613	19.7706	19.3517

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
370017	12.6400	13.6531	*	13.1855
370018	18.5107	17.7054	18.7928	18.3360
370019	14.2277	14.6216	16.1367	14.9616
370020	14.3798	15.1035	15.6057	15.0288
370021	12.0474	12.9030	*	12.4760
370022	17.2344	17.3724	18.2109	17.5986
370023	17.7630	17.5148	18.1255	17.8019
370025	17.4988	18.4815	19.1013	18.3736
370026	18.3371	18.0412	18.6982	18.3516
370028	18.4445	21.1292	22.1765	20.5544
370029	16.4924	18.2580	19.3285	17.9453
370030	16.3269	16.5803	18.1779	17.0344
370032	18.2821	18.1538	18.9050	18.4517
370033	13.5216	11.3210	15.3857	13.3051
370034	15.6386	15.6288	16.2204	15.8253
370035	25.5764	*	*	25.5764
370036	12.4026	12.4070	11.7667	12.1865
370037	16.7012	18.9556	20.6493	18.6793
370038	13.3084	13.0210	15.4551	13.8393
370039	15.5206	19.4498	22.3915	18.9462
370040	14.4672	15.5109	16.8127	15.5746
370041	16.7356	16.2316	14.7346	15.7346
370042	14.9175	15.2764	15.9005	15.3820
370043	15.9534	17.0892	19.8318	17.5204
370045	10.1994	11.3560	11.6163	10.9883
370046	18.8334	*	*	18.8334
370047	16.7554	17.8769	18.4743	17.6862
370048	18.2150	15.6803	17.0785	16.9957
370049	20.7176	19.4868	20.3405	20.1537
370051	11.6736	12.5171	11.4943	11.8576
370054	16.9049	18.0787	19.2294	17.9957
370056	18.4558	18.1432	18.9395	18.5020
370057	16.7261	15.1228	16.0301	15.9579
370059	18.1386	18.3314	20.1182	18.8407
370060	16.5403	19.3051	17.5989	17.7984
370063	14.4132	16.7342	*	15.4260
370064	10.9676	11.9954	11.6347	11.5257
370065	16.6898	18.1349	18.2406	17.6615
370071	16.1439	16.4567	*	16.2906
370072	14.4742	13.6519	12.5765	13.5464
370076	13.5694	14.3555	15.4067	14.4469
370078	18.4086	19.2412	15.2513	17.4148
370079	16.6861	16.9201	17.5915	17.0209
370080	13.9239	14.7323	14.3546	14.3090
370082	13.9634	15.0669	16.9715	15.2230
370083	13.1519	13.1810	15.6824	14.0210
370084	22.0545	13.1197	15.6184	16.0638
370085	11.2842	48.1271	*	16.2341
370086	15.4404	11.1900	*	13.0199
370089	16.0966	17.2638	17.9243	17.0970
370091	19.1698	20.1822	20.8553	20.0806
370092	14.9802	15.7678	16.8432	15.8798
370093	18.4600	19.7008	22.1966	20.1375
370094	18.0002	19.5462	19.5565	19.0506
370095	12.6383	13.4202	14.5909	13.5521
370097	22.9714	23.2056	19.0437	21.4568
370099	15.4549	19.4646	18.1467	17.5179
370100	14.0168	18.8274	12.9784	15.1185
370103	19.2353	18.2685	23.1347	19.9596
370105	21.3352	20.7890	25.1252	22.1529
370106	18.5485	20.3651	21.5826	20.1129
370108	12.3279	12.7470	14.0190	13.0228
370112	14.8539	15.3039	14.3384	14.8216

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
370113	16.1046	17.6107	19.9767	17.8205
370114	16.5268	17.8941	17.9757	17.4836
370121	22.5611	21.3099	19.3414	20.9750
370122	15.0645	15.4375	*	15.2280
370123	18.9159	19.0313	19.7958	19.2564
370125	15.6284	13.9436	14.4664	14.6695
370126	23.9654	15.8020	*	19.5933
370131	17.5689	15.7261	*	16.5772
370133	10.9575	12.9545	16.1855	13.3276
370138	16.4005	17.5551	17.4574	17.1263
370139	14.8612	14.9964	16.0898	15.3115
370140	16.0721	17.1393	17.4950	16.9403
370141	18.4101	20.7798	19.8606	19.6250
370146	12.6402	13.0399	13.9900	13.2166
370148	20.6458	20.6612	26.6722	22.4333
370149	16.1850	17.0929	18.0699	17.1239
370153	17.8352	16.4669	16.5267	16.9839
370154	15.5127	15.6093	16.6687	15.9283
370156	13.9255	14.5696	15.4303	14.6173
370158	15.6917	15.6994	16.3637	15.9128
370159	28.0536	21.1267	25.3240	24.1146
370163	17.6361	20.4217	*	18.9027
370165	13.0910	13.0375	12.9569	13.0294
370166	17.2849	21.0797	19.4219	19.1747
370169	12.5243	12.7138	14.8384	13.3173
370176	15.9476	18.9951	19.6537	18.1230
370177	11.2536	14.6481	14.1304	13.3001
370178	10.5726	11.6200	9.8655	10.5383
370179	17.2829	21.3002	23.8404	20.1287
370183	10.2945	16.9318	16.6061	14.0419
370186	13.6192	15.4533	16.3671	15.1316
370190	14.1397	19.3570	20.6398	17.5727
370192	18.4614	19.6967	21.8343	20.0562
370198	21.3136	*	*	21.3136
370200	*	22.5299	18.3941	20.2627
370201	*	*	18.2548	18.2548
370202	*	*	16.4919	16.4919
370203	*	*	23.5454	23.5454
380001	20.3127	26.4822	25.1542	23.6052
380002	24.0241	21.9185	23.2479	22.9299
380003	21.7826	20.9007	23.8074	22.1844
380004	23.1451	23.3609	24.5418	23.6963
380005	24.0838	25.0750	24.7476	24.6467
380006	21.2731	21.3520	20.5914	21.0574
380007	25.2995	32.2678	25.9239	27.5188
380008	20.7063	22.3004	21.6133	21.5417
380009	23.8104	24.3851	25.1040	24.4366
380010	23.7488	22.7276	24.1931	23.5774
380011	21.1151	20.3357	20.6759	20.7167
380013	18.6818	19.8180	20.3705	19.6316
380014	24.6574	25.9828	26.6038	25.7705
380017	26.0578	25.3954	21.9236	24.5037
380018	22.3525	22.9822	24.8661	23.4431
380019	22.1215	20.8176	21.1743	21.3400
380020	20.1464	22.9568	23.9978	22.4898
380021	21.1590	23.8499	24.4365	23.1615
380022	22.6408	24.5974	25.6255	24.2510
380023	20.5462	21.3831	23.4328	21.9485
380025	26.3652	26.9346	26.9398	26.7561
380026	20.4706	20.6972	22.7561	21.3218
380027	20.8647	21.5490	22.2573	21.6028
380029	19.4246	20.1471	22.0371	20.5671
380031	23.3181	20.3396	23.7634	22.5126

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
380033	25.2454	27.1343	26.6899	26.3003
380035	22.4099	23.9719	25.6016	23.9444
380036	27.1587	27.2157	*	27.1858
380037	21.9158	22.1774	23.4798	22.5697
380038	26.0869	26.7759	28.1436	26.9990
380039	23.1746	22.8048	25.7614	23.8428
380040	26.2717	22.5477	22.6412	23.5906
380042	21.1176	24.4172	21.6793	22.3496
380047	23.0718	24.2524	25.2591	24.2189
380048	17.5885	18.3005	18.2773	18.0623
380050	20.3934	20.3205	22.1089	20.9066
380051	22.3568	22.3207	24.4081	23.0351
380052	19.4570	18.6299	20.7431	19.6320
380056	19.5185	18.4961	20.7895	19.6447
380060	24.2670	24.2059	23.0106	23.8515
380061	22.3736	22.8781	24.1121	23.0785
380062	20.7716	18.2148	25.9782	21.7912
380063	20.4077	*	*	20.4077
380064	19.9826	22.9160	27.0627	23.2721
380065	26.1404	22.9608	23.3146	24.0398
380066	22.0349	23.2794	23.1175	22.8287
380068	22.3178	*	*	22.3178
380069	19.8300	20.4882	21.2057	20.5172
380070	27.2541	27.7790	29.9706	28.3711
380071	22.6386	25.1808	25.7299	24.5669
380072	19.1553	19.4346	20.6568	19.7391
380075	22.3625	22.4139	23.1910	22.6625
380078	20.2507	21.0903	22.6996	21.3468
380081	20.9882	20.4082	22.9805	21.4341
380082	22.2275	22.9606	23.7927	23.0290
380083	21.3859	21.7431	22.4058	21.8126
380084	24.2844	27.1689	31.0111	27.0317
380087	16.5309	17.0380	21.3119	18.4448
380088	21.5225	19.5346	24.8158	21.8578
380089	19.5255	25.2908	26.1967	23.9671
380090	29.2702	24.9351	30.4223	28.0439
380091	27.5560	25.3062	28.7846	27.2892
390001	19.2989	19.6732	20.3350	19.7868
390002	21.8353	19.7833	21.0159	20.9278
390003	17.1371	18.1025	18.0436	17.7426
390004	19.2277	20.3204	20.0557	19.8647
390005	17.3506	16.9472	19.0218	17.7359
390006	20.2959	21.1786	21.8940	21.0893
390007	21.7506	21.3839	*	21.5715
390008	17.8297	18.2743	19.3496	18.4745
390009	20.6507	20.6241	22.5580	21.2847
390010	17.5127	17.3335	18.1275	17.6598
390011	18.1717	18.3257	18.2751	18.2595
390012	20.6523	21.0610	22.1912	21.3051
390013	19.2698	19.6562	20.2186	19.7244
390015	13.1337	13.7352	14.3138	13.7169
390016	16.9892	17.1133	17.3854	17.1611
390017	16.7493	18.6113	18.5869	17.9293
390018	21.3626	19.0279	20.0672	20.1854
390019	16.7848	17.7258	18.7609	17.7608
390022	21.5064	24.8468	24.7121	23.6803
390023	21.8270	22.1044	23.5236	22.6164
390024	24.9437	25.4606	27.7643	26.0343
390025	15.6155	15.5523	14.5309	15.2361
390026	22.3902	22.9718	*	22.6895
390027	26.8878	29.5940	*	28.2192
390028	22.7700	23.6571	22.7820	23.0704
390029	21.5729	21.2661	24.4753	22.2475

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
390030	17.9580	18.6887	18.9093	18.5094
390031	19.2755	18.8162	19.1781	19.0917
390032	17.8041	21.5105	18.7616	19.2843
390035	20.2029	22.3591	21.9021	21.4643
390036	19.9880	19.7671	20.1769	19.9773
390037	21.0616	20.4263	19.9175	20.4619
390039	17.1046	17.5300	17.6176	17.4167
390040	15.9612	16.6876	17.4451	16.6853
390041	19.8080	20.4397	19.6159	19.9368
390042	22.7693	22.5775	21.7857	22.3776
390043	17.2607	17.4764	17.9549	17.5603
390044	20.2813	20.9831	21.3382	20.8726
390045	18.5574	19.4677	*	19.0190
390046	20.7303	21.7445	21.8760	21.4470
390047	27.6661	26.9709	*	27.3457
390048	19.0920	19.7992	18.8322	19.2254
390049	21.1217	22.1586	22.7306	21.9927
390050	22.8808	22.2639	24.7169	23.2216
390051	25.7910	28.1385	*	26.8617
390052	20.9306	20.1195	21.2367	20.7439
390054	17.8852	18.4975	19.5598	18.6230
390055	24.2211	23.4017	25.7327	24.4723
390056	17.7858	19.3901	21.4121	19.5072
390057	20.2059	20.2395	21.6693	20.6975
390058	19.7379	20.3520	20.7930	20.2983
390061	21.2392	23.8722	22.8728	22.6127
390062	16.6721	17.3750	17.4710	17.1692
390063	20.0125	19.4965	20.1696	19.9019
390065	19.9361	20.0473	20.2930	20.0884
390066	19.8539	18.9296	18.9776	19.2407
390067	20.9688	20.8162	21.9905	21.2535
390068	18.3158	19.1109	21.6408	19.5148
390069	19.6466	*	*	19.6466
390070	16.1988	21.8549	22.7909	20.2250
390071	15.7165	16.0100	18.9416	16.7655
390072	16.3133	16.9232	15.1402	16.1159
390073	20.5581	21.2623	22.2009	21.3579
390074	18.4806	18.3093	19.5799	18.7617
390075	17.9840	18.7695	19.5744	18.6643
390076	20.2475	21.3290	19.7719	20.4342
390078	19.2089	19.0156	20.5750	19.5586
390079	18.3312	18.9269	19.2984	18.8525
390080	18.8028	21.4707	22.2449	20.7685
390081	24.8351	24.7461	25.6575	25.0775
390083	*	*	26.1660	26.1660
390084	16.4026	20.2529	17.0197	17.7133
390086	18.5265	18.3563	*	18.4381
390088	23.6173	23.9506	*	23.7777
390090	21.6437	21.3759	20.5444	21.2031
390091	18.1569	18.3770	18.8545	18.4554
390093	17.7171	18.4442	20.0135	18.7217
390095	16.3357	16.6930	17.9697	16.9815
390096	19.1171	22.4382	21.5922	20.9351
390097	23.5963	25.2845	24.8005	24.5139
390100	20.7859	20.9263	21.1186	20.9469
390101	17.9499	18.5039	17.0447	17.8109
390102	19.0461	21.5496	18.0199	19.5593
390103	18.4312	18.8667	20.4422	19.2092
390104	15.9008	16.3255	16.2440	16.1553
390106	16.6666	16.8439	*	16.7557
390107	19.5178	20.9841	20.6024	20.3811
390108	21.0899	21.3142	21.2602	21.2184
390109	16.4597	16.5299	17.4540	16.8127

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
390110	21.5282	21.6464	21.6005	21.5915
390111	27.5193	33.3971	27.0087	29.3495
390112	14.9427	15.0065	14.8634	14.9388
390113	19.1945	19.3634	19.9496	19.4908
390114	19.6295	20.9533	19.8004	20.1209
390115	23.3461	21.4287	21.9789	22.1926
390116	21.4877	21.3671	22.6783	21.8481
390117	17.9393	18.0769	18.2543	18.0888
390118	18.3440	18.9507	16.9990	18.1121
390119	18.2951	18.8815	19.3946	18.8604
390121	20.8780	19.1315	20.6253	20.2089
390122	17.1902	17.7734	15.5438	16.7430
390123	20.8344	21.3974	21.8434	21.3548
390125	16.7983	17.5446	17.0975	17.1374
390126	20.6498	*	*	20.6498
390127	21.7724	22.4555	22.8787	22.3758
390128	19.6792	19.3165	19.9764	19.6532
390130	17.7049	18.3695	18.5519	18.2059
390131	16.0986	19.2096	18.7142	17.9603
390132	21.1931	22.8414	24.1878	22.7048
390133	23.3489	24.7561	24.1814	24.0439
390135	21.5782	22.1905	21.8152	21.8560
390136	16.9737	20.6286	16.8505	18.1580
390137	17.5687	18.5397	19.1432	18.3744
390138	19.6212	20.6936	20.7726	20.3703
390139	24.4515	23.9757	23.8019	24.0822
390142	26.8086	28.8877	28.3448	28.0760
390145	20.3731	20.4228	20.4964	20.4300
390146	18.7922	18.6505	20.1788	19.1967
390147	20.9651	21.2492	21.7600	21.3199
390150	20.7294	20.3155	20.8970	20.6500
390151	21.6000	22.5206	23.6072	22.6096
390152	20.3353	19.4017	20.2581	19.9941
390153	23.7013	22.9707	23.3587	23.3403
390154	17.4036	16.7052	17.8774	17.3537
390156	21.8498	22.6398	*	22.2353
390157	19.6578	19.1783	20.2647	19.6975
390160	21.4810	19.4463	18.8676	19.8186
390161	16.4799	*	*	16.4799
390162	21.4095	21.9188	21.4600	21.5967
390163	16.8013	17.7564	18.1415	17.5746
390164	24.6765	24.9750	25.0347	24.8814
390166	19.0405	19.7978	19.8899	19.5577
390167	19.8973	*	*	19.8973
390168	18.7400	18.8863	19.6875	19.1127
390169	20.2382	22.0547	22.7920	21.7176
390170	26.5891	24.7973	*	25.6898
390173	18.5370	18.6613	18.7403	18.6472
390174	25.4189	25.3307	25.7174	25.4826
390176	17.8740	20.8368	21.7650	20.0495
390178	16.6993	17.0534	17.1142	16.9526
390179	21.6901	21.8593	21.6191	21.7220
390180	25.7074	26.5541	26.7743	26.3551
390181	19.4654	19.3832	18.8681	19.2465
390183	17.8306	17.9848	17.4535	17.7535
390184	20.8060	20.9349	21.1941	20.9693
390185	18.8798	20.3877	20.3301	19.8556
390189	20.0889	20.3338	19.0797	19.7997
390191	16.3240	17.2270	17.1919	16.8998
390192	17.4537	17.6597	17.1875	17.4275
390193	16.7874	18.1209	17.3804	17.3866
390194	20.7953	21.2689	21.0549	21.0283
390195	24.6855	24.1793	23.4250	24.1067

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
390197	19.2690	20.7998	22.1769	20.7816
390198	15.9721	15.8833	16.6803	16.1535
390199	17.0515	17.3865	17.7763	17.3987
390200	15.1399	15.4012	18.2456	16.2785
390201	20.6296	20.3533	21.3291	20.7767
390203	20.9432	21.4989	22.4685	21.6448
390204	20.1779	22.9616	22.1541	21.7608
390206	18.4027	*	*	18.4027
390209	17.4792	18.7059	16.8200	17.6370
390211	17.8638	18.4213	19.4552	18.6187
390213	18.8555	19.1553	19.3776	19.1155
390215	20.7084	21.2032	23.5953	21.7981
390217	19.1406	19.9837	19.9665	19.6808
390219	18.8292	19.6226	20.1311	19.5227
390220	18.7178	17.7916	*	18.2413
390222	21.5739	22.1548	22.7491	22.1668
390223	23.6482	22.1775	18.9493	21.4503
390224	15.3015	13.7518	17.2173	15.1752
390225	18.6125	18.7290	19.0364	18.7963
390226	21.8268	21.8481	22.7772	22.1197
390228	19.4083	19.8180	20.2703	19.8379
390231	22.7544	19.4798	21.3811	21.0947
390233	19.4887	20.2309	20.6673	20.1413
390235	25.0857	21.4200	19.9925	22.7713
390236	16.2397	17.8735	19.1427	17.7118
390237	19.5230	22.3011	*	20.8354
390238	17.8211	17.1055	18.1956	17.6820
390244	15.4611	15.6402	13.8845	14.9996
390245	26.0194	24.5076	*	25.2650
390246	18.9733	25.0556	22.3892	21.9107
390247	20.9526	21.2151	*	21.0479
390249	12.7920	13.1657	14.1062	13.3677
390256	23.2734	22.2773	22.3540	22.6670
390258	21.9207	22.6852	23.8318	22.8365
390260	21.9509	21.5982	*	21.7740
390262	18.2379	*	18.8942	18.5346
390263	20.6855	20.3796	20.6348	20.5647
390265	20.3580	20.4950	20.4760	20.4411
390266	17.1666	17.1966	17.5653	17.3117
390267	21.2974	19.2665	19.9578	20.2867
390268	21.3486	22.0909	22.2046	21.8827
390270	19.0925	19.2074	20.6793	19.6201
390278	18.2865	17.7176	18.5776	18.2038
390279	14.3241	14.8655	15.8080	14.9814
390283	*	22.5490	*	22.5490
390284	*	34.3904	*	34.3904
390285	*	*	29.1270	29.1270
390286	*	*	22.9746	22.9746
390287	*	*	30.3252	30.3252
390288	*	*	26.9662	26.9662
390289	*	*	22.8963	22.8963
390290	*	*	30.5037	30.5037
390291	*	*	20.0272	20.0272
390293	*	*	23.5285	23.5285
400001	9.9463	10.5757	10.7531	10.4326
400002	10.1417	13.0494	13.3684	12.2030
400003	10.8821	12.4078	11.2726	11.5031
400004	8.9864	8.5648	9.0781	8.8776
400005	9.5632	7.7432	9.7802	8.9053
400006	10.3444	10.1048	10.4988	10.3215
400007	6.4490	8.0174	8.1974	7.5138
400009	8.4207	8.8650	8.7341	8.6758
400010	10.6518	10.8011	9.1359	10.1542

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
400011	7.4979	8.5426	8.6252	8.2277
400012	8.2412	8.4728	8.6538	8.4546
400013	8.4579	9.2624	9.8197	9.2598
400014	9.5235	9.4798	10.2712	9.7458
400015	10.9505	14.4076	15.5827	13.3370
400016	13.2756	13.3922	13.7001	13.4570
400017	8.6421	9.2577	9.9167	9.2527
400018	10.4557	10.6208	10.5583	10.5484
400019	10.4332	10.8940	11.5139	11.0095
400021	10.6988	12.1434	12.7462	11.9145
400022	11.5861	12.2199	13.0411	12.2767
400024	7.8984	9.2409	9.0826	8.6750
400026	5.6454	5.8335	7.4280	6.2931
400027	9.5899	*	*	9.5899
400028	8.8597	19.1794	8.9567	8.9909
400031	8.2660	*	*	8.2660
400032	10.5498	10.0448	10.1898	10.2599
400044	11.9704	11.9486	12.8671	12.2011
400048	9.1701	15.1405	11.5104	11.4186
400061	12.4493	13.0988	10.3664	11.9076
400079	*	9.7203	8.7218	9.1657
400087	9.5097	9.8534	8.6480	9.3956
400094	8.9116	7.9187	8.8387	8.5180
400098	9.3308	9.7791	10.4312	9.8607
400102	9.8536	9.9903	8.5290	9.4812
400103	11.2069	11.5359	11.8454	11.4791
400104	11.0672	10.7292	7.9552	10.3151
400105	9.3049	9.0556	10.6028	9.5117
400106	9.3123	9.2187	9.8694	9.4766
400109	10.9826	11.8760	*	11.4480
400110	10.3326	10.5277	10.7228	10.5456
400111	9.5583	10.9665	12.3311	11.0412
400112	10.1755	10.8694	11.0634	10.7058
400113	9.2238	8.3168	9.3955	8.9859
400114	9.0496	7.0510	9.9477	8.5888
400115	9.8244	8.5487	7.2203	8.5322
400117	10.2295	10.8756	11.3351	10.8116
400118	9.4398	11.4051	11.4317	10.7997
400120	9.5274	10.6584	10.9315	10.3832
400121	7.8052	9.8322	8.7584	8.8340
400122	8.1911	7.6413	9.1638	8.3405
400123	7.8099	10.2367	10.3955	9.4702
400124	12.0999	12.2452	12.7323	12.3713
400125	*	10.2056	10.5997	10.3924
410001	23.2808	23.1738	22.4972	22.9875
410004	22.4801	21.0638	22.8898	22.1691
410005	23.1444	22.7170	23.8848	23.2434
410006	23.3968	23.8700	22.7636	23.3233
410007	22.1452	23.1325	22.4988	22.5921
410008	23.0662	24.9726	24.4170	24.1518
410009	24.4899	24.3895	24.3760	24.4190
410010	26.9813	28.4589	29.0876	28.1660
410011	25.2926	26.1183	27.1700	26.1594
410012	24.5811	24.1695	26.4570	25.0414
410013	24.5122	24.8800	24.8429	24.7494
420002	19.4845	20.7804	22.6182	20.9552
420004	19.7968	20.9588	16.3147	18.8438
420005	17.3510	17.9694	17.8103	17.7120
420006	18.3439	19.1760	18.7168	18.7347
420007	18.2096	18.6456	18.9047	18.5717
420009	18.5456	19.9586	21.2566	19.9500
420010	17.1184	18.0252	19.3267	18.2127
420011	16.5664	18.0970	16.7523	17.1112

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
420014	16.6065	18.0519	19.0455	17.8775
420015	18.8411	20.1164	20.8736	19.8858
420016	15.6241	15.5485	15.4358	15.5337
420018	19.7367	21.8775	18.7117	19.9976
420019	16.9990	17.1726	19.0199	17.6834
420020	20.9449	20.3193	20.5801	20.5993
420023	19.4855	20.4053	20.4978	20.1490
420026	20.3476	21.8749	23.3274	21.9111
420027	18.8457	19.2594	19.6743	19.2679
420030	19.1453	20.6448	22.5159	20.8443
420031	14.1855	8.2516	15.2208	11.5692
420033	21.7279	23.1303	23.7974	22.8884
420036	17.6136	21.3222	19.8080	19.4992
420037	21.7908	22.7099	23.5244	22.7289
420038	17.6726	18.6568	20.0181	18.7610
420039	15.8385	18.3017	17.7880	17.2992
420043	19.4521	19.7570	19.6834	19.6347
420048	18.4367	18.8070	20.4905	19.2520
420049	17.5854	19.4049	20.6238	19.1796
420051	19.5001	19.1555	19.8549	19.5061
420053	16.9599	18.1657	19.0780	18.0364
420054	18.2702	20.2574	20.2275	19.5600
420055	19.2048	16.8717	18.6782	18.0932
420056	14.8695	15.1835	16.5491	15.4839
420057	15.9849	20.5266	22.1312	19.6895
420059	15.8160	17.1483	18.2093	17.0936
420061	16.5555	17.3543	17.7047	17.2228
420062	17.8205	21.7469	20.9032	20.1974
420064	16.7227	16.0794	19.7067	17.5583
420065	19.6902	19.9435	19.2150	19.5969
420066	15.1804	18.0042	19.5366	17.5193
420067	18.8610	19.7824	20.7769	19.8307
420068	18.5030	18.5481	20.2580	19.1326
420069	17.0788	18.1298	18.9003	18.0124
420070	18.0057	17.3876	18.8535	18.0764
420071	19.4482	20.3902	20.1145	19.9887
420072	13.8550	15.0158	18.2531	15.7212
420073	19.1604	19.9986	20.2697	19.8499
420074	16.9292	18.0967	18.1839	17.6249
420075	14.2931	12.8158	15.0132	14.0442
420078	20.7317	21.9082	22.7156	21.7962
420079	20.8639	21.0874	21.3177	21.0994
420080	22.3443	21.9968	*	22.1649
420082	20.4653	21.7210	22.7391	21.6447
420083	20.1472	22.6376	24.0994	22.2410
420085	19.9603	21.6791	22.0071	21.2571
420086	25.7179	20.2878	23.7341	23.0645
420087	19.1403	19.8388	20.8217	19.9506
420088	17.1938	19.9919	21.8979	19.5872
420089	20.2537	20.5360	21.3954	20.7386
420091	18.8687	20.3092	21.8367	20.2654
420093	17.4689	18.3902	19.1299	18.3060
420095	*	*	33.4632	33.4632
420096	*	*	26.4863	26.4863
430004	18.5438	19.6344	19.2737	19.1454
430005	16.3059	16.4560	17.3400	16.6979
430007	14.1078	14.6331	15.1494	14.6319
430008	17.6640	18.1323	18.5234	18.0977
430010	17.1766	19.8191	16.5750	17.7180
430011	16.9848	17.4750	18.3648	17.6074
430012	17.2775	17.6997	19.2921	18.0907
430013	18.1338	18.4817	18.8978	18.5085
430014	16.8925	20.2387	20.9118	19.1361

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
430015	18.0019	18.2875	18.8998	18.3871
430016	19.4759	20.8850	21.2191	20.5077
430018	14.8854	16.2244	15.9424	15.6759
430022	13.4905	14.5118	14.0661	13.9980
430023	12.2331	16.2164	16.7850	14.8010
430024	15.4709	16.1801	17.4816	16.3448
430027	19.1461	20.2591	20.8666	20.0818
430028	18.2312	17.1577	18.2829	17.8947
430029	16.6500	17.6986	17.4932	17.2971
430031	13.1258	12.4660	13.2105	12.9278
430033	15.3003	17.3652	18.3978	16.9036
430034	15.4064	14.2491	13.8535	14.4964
430036	13.6967	15.6258	16.7827	15.2466
430037	16.5368	18.1293	18.7009	17.7855
430038	13.7167	18.4078	*	15.7522
430040	13.6745	14.4509	14.7860	14.2554
430041	13.1936	14.8816	*	14.0079
430043	13.6908	14.9949	17.0193	15.1103
430044	18.4970	21.0823	*	19.6187
430047	17.4956	17.9823	17.5377	17.6691
430048	18.3524	18.7602	19.0261	18.7260
430049	15.5381	15.2237	14.9025	15.2275
430051	17.0574	18.8070	18.8697	18.2650
430054	14.7251	14.8003	15.0101	14.8472
430056	11.7627	10.3697	14.1914	11.9246
430057	15.4390	17.2805	18.8777	17.1911
430060	9.0358	10.0176	9.7678	9.6151
430064	14.4367	14.2184	13.8666	14.1634
430066	14.3557	15.6660	14.5957	14.8566
430073	16.1133	15.3776	16.5112	15.9989
430076	12.7608	13.9883	15.2453	13.9494
430077	19.3012	19.8558	20.4361	19.8699
430079	13.6836	14.1815	14.4154	14.0719
430089	17.8908	17.9790	17.5100	17.7870
430090	21.5239	21.5974	23.5180	22.2918
430091	19.2146	18.1567	21.6239	20.0217
430092	*	21.3807	19.7644	20.5428
430093	*	19.5013	23.3009	21.3125
440001	14.8713	15.5897	17.2282	15.8569
440002	19.1498	20.3740	21.4299	20.3167
440003	18.3658	19.3042	20.3756	19.3464
440006	19.6021	21.4055	23.1483	21.3134
440007	12.1230	14.8959	14.0612	13.6386
440008	17.2848	18.8994	20.3303	18.7894
440009	17.8424	17.4831	18.4068	17.9080
440010	19.9829	16.3283	13.3692	16.2699
440011	17.6948	18.3375	19.3165	18.4706
440012	15.9837	19.5739	19.6437	18.4174
440014	15.9195	16.1143	15.0656	15.7064
440015	18.2632	22.0659	21.6106	20.5435
440016	15.4097	16.2964	14.6142	15.3378
440017	19.6215	20.4563	20.2241	20.0945
440018	16.4115	17.4995	18.1059	17.3355
440019	20.0416	21.5402	23.2963	21.6131
440020	18.1154	17.8879	19.0396	18.3371
440022	15.8459	*	*	15.8459
440023	15.4721	16.7837	15.6603	15.9134
440024	18.4432	18.4046	18.4276	18.4251
440025	15.8784	16.3140	17.0997	16.4428
440026	23.0550	23.2566	25.6490	23.8993
440029	19.4326	20.7050	22.2889	20.8403
440030	16.2941	16.9925	17.6297	17.0242
440031	15.5432	17.0211	17.2555	16.5726

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
440032	13.9775	13.8140	13.9784	13.9249
440033	14.5304	13.7328	16.4679	14.8744
440034	19.5470	20.0309	20.9470	20.1907
440035	18.9026	19.3034	20.4168	19.5344
440039	19.9439	21.6536	22.4158	21.3378
440040	16.3740	16.9275	17.6781	16.9632
440041	14.6621	14.9545	14.6684	14.7645
440046	18.1654	19.3229	20.5562	19.3415
440047	16.6646	17.8092	18.7469	17.7021
440048	19.4498	21.4993	19.6052	20.1565
440049	17.9292	18.7967	19.3000	18.6741
440050	19.1328	18.2511	19.7915	19.0510
440051	13.1901	16.0421	17.7067	15.5027
440052	16.6541	19.8075	18.1377	18.1083
440053	18.5515	19.6494	21.5253	19.8982
440054	13.8716	13.3967	15.2154	14.1791
440056	15.9821	16.2742	20.4903	17.3863
440057	12.7925	13.7257	14.4363	13.6135
440058	18.8118	19.1878	17.1548	18.4084
440059	18.5418	19.6018	20.8882	19.6895
440060	18.0586	19.7916	20.7628	19.4260
440061	14.9708	22.5525	16.9234	17.8112
440063	19.3222	19.8371	18.8061	19.2994
440064	17.7652	18.9809	18.2678	18.2991
440065	18.5825	18.8296	19.2282	18.8924
440067	16.2811	17.2397	18.2973	17.2997
440068	19.4695	19.3668	19.4392	19.4232
440070	13.7035	14.0437	18.0064	15.1918
440071	17.0186	19.7836	*	18.2110
440072	17.5995	19.1522	20.0691	18.8963
440073	19.1714	19.5554	19.6290	19.4550
440078	15.0849	16.0188	17.1645	15.9789
440081	18.3587	19.3454	20.7215	19.5016
440082	22.2857	22.6855	22.5590	22.5073
440083	14.8525	13.7423	13.7630	14.1806
440084	13.4378	13.7731	13.8085	13.6799
440091	19.6114	20.1065	20.1359	19.9669
440100	13.8437	14.7113	15.9969	14.8524
440102	14.3510	14.5500	16.0783	14.9840
440103	20.3052	18.6990	*	19.4877
440104	22.4403	22.6754	21.7135	22.2610
440105	16.7131	17.1172	18.1375	17.2950
440109	16.0446	17.7443	17.6399	17.0830
440110	21.1716	17.4816	18.4998	18.8996
440111	23.2425	23.2254	23.2111	23.2266
440114	14.4997	15.0036	18.5327	16.0830
440115	17.4514	18.5457	18.7054	18.2287
440120	17.2384	16.3115	19.8997	17.7817
440125	15.6588	19.4115	19.6848	18.2807
440130	17.8223	17.4857	19.0905	18.1589
440131	15.5048	16.1214	19.9883	17.1760
440132	16.6553	16.8871	17.9186	17.1418
440133	21.5313	23.0891	18.7556	21.1283
440135	19.2010	22.2005	22.5452	21.4251
440137	14.5632	15.0070	15.3530	14.9670
440141	13.5308	15.9429	17.6819	15.3875
440142	15.7287	16.8855	17.1483	16.5303
440143	17.7821	18.2061	18.6844	18.2206
440144	17.6415	18.3859	18.8127	18.2853
440145	17.0608	18.3948	18.3832	17.9140
440147	21.4304	26.1464	25.3766	24.0818
440148	19.2435	19.4598	19.3769	19.3574
440149	16.6923	18.4281	18.4869	17.8895

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
440150	20.1411	20.3006	21.2942	20.5974
440151	17.4248	18.3928	19.8977	18.5439
440152	21.0287	22.7664	26.2972	22.9356
440153	16.7769	16.5716	18.1975	17.1720
440156	29.5557	21.7577	21.9374	23.7510
440157	16.9265	18.4249	15.5316	17.0209
440159	17.7158	20.9371	21.4914	19.6375
440161	21.8013	22.8816	23.3891	22.6977
440162	14.7637	15.5534	19.8075	16.5656
440166	19.6684	19.2159	19.6632	19.5183
440168	18.6535	19.1509	21.1947	19.6498
440173	18.6402	19.1812	21.0284	19.6315
440174	17.3294	18.0865	19.3966	18.2367
440175	20.0802	18.5186	19.9065	19.4762
440176	18.0294	19.2208	19.8448	19.0126
440180	19.7773	20.2184	17.8427	19.2624
440181	16.4878	17.7709	19.0915	17.6551
440182	17.7487	19.7094	18.1953	18.4985
440183	22.7067	21.3465	22.2401	22.0840
440184	17.2037	16.8880	18.6890	17.3933
440185	19.3870	21.2188	21.1226	20.6133
440186	19.3948	19.7983	18.0450	19.1060
440187	18.9713	17.5872	16.0274	17.5444
440189	*	18.5252	22.2555	20.3772
440192	19.0839	19.1705	19.1976	19.1524
440193	19.0811	18.6999	19.9078	19.2111
440194	19.8682	22.4562	21.9609	21.4700
440197	21.9618	21.8503	22.5282	22.1263
440200	17.9575	19.8078	17.8595	18.5432
440203	18.3400	16.2861	16.9819	17.1896
440206	16.4429	*	*	16.4429
440210	11.0218	11.9815	12.3270	11.8072
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
440217	*	*	19.2834	19.2834
450002	21.3749	21.4836	21.5141	21.4583
450004	16.6723	16.7850	15.9549	16.5100
450005	18.3600	16.6396	16.6354	17.2368
450007	16.9681	19.1910	17.7721	17.9505
450008	17.0832	17.6582	19.3637	18.0034
450010	16.5001	17.6677	18.5058	17.7858
450011	17.1942	20.8102	18.9490	18.9450
450014	17.9495	17.5815	18.4937	17.9967
450015	18.9895	21.6773	23.3972	21.2507
450016	18.4463	18.3456	18.9063	18.5621
450018	21.4788	23.2293	*	22.2764
450020	17.8415	19.1153	18.4454	18.4795
450021	23.0843	23.3630	22.5937	23.0174
450023	16.0831	17.6360	19.2810	17.6838
450024	17.3518	18.5985	19.5584	18.5411
450025	17.0004	*	*	17.0004
450028	18.8764	19.1658	19.5905	19.2141
450029	17.4716	17.7425	19.7835	18.3585
450031	22.2222	29.6945	29.6772	27.1869
450032	17.3317	14.6530	20.8525	17.3455
450033	19.7437	21.0222	21.4646	20.7635
450034	19.6721	18.8823	19.4439	19.3269
450035	20.0951	20.3599	20.2269	20.2257
450037	19.5411	19.9140	19.3682	19.6099
450039	19.8143	19.7176	18.4497	19.3230

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450040	16.8534	19.6370	*	18.3093
450042	19.8921	18.8357	20.2402	19.6613
450044	24.7961	21.0909	23.4476	22.9976
450046	18.6536	17.3631	18.1393	18.0789
450047	13.4486	16.9028	15.9525	15.2979
450050	14.7669	17.7209	19.1390	17.0907
450051	21.0236	21.1008	22.4159	21.4934
450052	13.8881	15.5890	16.3064	15.2550
450053	17.0467	17.2781	15.6962	16.7365
450054	22.8960	19.2431	*	21.4583
450055	15.0433	15.8526	16.4789	15.8195
450056	21.8436	21.8605	21.6890	21.7982
450058	18.0967	18.6172	20.0081	18.9393
450059	15.2168	19.8240	21.4873	18.7159
450063	14.3815	12.7211	15.1779	13.9190
450064	17.4093	19.7682	21.3929	19.5099
450065	21.4934	23.3797	23.8471	22.8509
450068	22.8998	23.3495	22.8227	23.0189
450072	19.0111	18.0307	20.0134	19.0500
450073	17.1002	16.5942	23.7700	19.3382
450078	11.7265	13.2820	13.9324	12.9289
450079	21.0518	20.6483	22.0609	21.2553
450080	17.4553	18.6212	19.7834	18.5898
450081	16.3448	17.5737	19.0276	17.6152
450082	16.1585	16.8677	*	16.5390
450083	21.5884	23.3754	20.9315	21.9323
450085	18.3602	20.0085	15.7805	17.8575
450087	22.0273	21.9320	23.4141	22.4951
450090	15.0939	15.5796	19.9180	16.7400
450092	16.8260	17.9520	15.7252	16.8197
450094	21.3158	23.2863	25.2158	23.1854
450096	17.8813	18.6802	19.3681	18.6265
450097	19.5723	19.7187	20.4932	19.9373
450098	20.5754	19.0454	19.3458	19.6276
450099	19.2258	20.4181	19.0079	19.5047
450101	17.1330	17.7928	*	17.4479
450102	18.6707	19.8793	21.4361	19.9466
450104	16.6744	17.0821	17.6834	17.1430
450107	25.1986	24.1094	20.9852	23.2733
450108	15.6324	15.2797	16.9845	15.9966
450109	13.8127	10.5973	17.7226	13.4301
450110	19.5821	*	*	19.5821
450111	19.6350	21.4908	*	20.6248
450112	16.0441	18.1026	17.3725	17.2066
450113	20.9777	20.8306	20.7782	20.8679
450118	17.9053	*	*	17.9053
450119	20.2853	20.2030	20.1335	20.2023
450121	20.4641	21.9198	22.0485	21.4762
450123	15.7618	14.1755	17.5051	15.6216
450124	22.7480	22.5208	22.6668	22.6449
450126	21.7233	21.4789	22.5290	21.9115
450128	18.2184	18.1446	18.4178	18.2629
450130	20.4156	18.9211	19.3882	19.5769
450131	19.2589	17.4168	17.7234	18.0882
450132	18.1713	21.8089	19.7672	19.9308
450133	23.6366	26.0763	24.4799	24.6993
450135	21.0306	20.4068	25.8775	22.4267
450137	22.4590	23.4346	21.3644	22.3582
450140	20.2280	17.3370	19.6205	19.0889
450143	14.5270	15.0871	16.7371	15.4651
450144	18.1121	17.4309	20.6880	18.7404
450145	15.6078	16.1895	16.4087	16.0604
450146	17.8572	15.5030	17.4391	16.8224

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450147	18.9363	19.0477	20.0805	19.3489
450148	18.6758	20.4923	20.9373	20.1433
450149	19.7521	21.7219	22.6138	21.3072
450150	16.3719	17.8612	18.3079	17.5184
450151	15.2906	16.4209	16.3279	16.0117
450152	18.0061	17.7265	19.6105	18.4659
450153	19.4419	18.6514	18.8000	18.9747
450154	13.8731	13.9119	16.8748	14.8870
450155	11.5841	13.3456	20.0872	14.3751
450157	15.6371	15.3083	16.8569	15.9683
450160	16.6533	10.6852	18.7780	14.2553
450162	20.9560	21.9218	20.5032	21.1178
450163	17.5403	17.8028	19.0727	18.1175
450164	16.9741	17.7180	18.7101	17.7835
450165	13.9218	17.3283	14.9478	15.3028
450166	11.4772	11.0541	11.3813	11.3012
450169	13.1990	*	*	13.1990
450170	14.2997	14.3234	15.8525	14.8194
450176	16.9674	17.2576	18.2050	17.4802
450177	14.9241	15.2419	14.8306	14.9994
450178	17.8508	16.0280	15.8729	16.5762
450181	15.5622	18.6936	18.3600	17.5713
450184	21.1263	20.0821	20.3941	20.5023
450185	14.0714	11.5228	13.2613	12.8423
450187	16.6945	18.5053	20.6388	18.5641
450188	14.3938	15.1954	16.9407	15.5553
450191	20.1222	20.9512	20.5883	20.5559
450192	20.3795	21.2497	20.1419	20.5690
450193	23.1963	23.1639	24.9007	23.7654
450194	20.5187	20.7745	20.5396	20.6114
450196	17.1955	17.8993	20.2663	18.3910
450200	18.7387	19.2228	19.6496	19.1969
450201	16.9908	17.1463	17.7763	17.3128
450203	20.6712	19.3978	19.6050	19.8895
450209	19.0811	20.0140	21.0205	19.9890
450210	13.9758	16.3470	16.7204	15.7370
450211	17.9857	18.8114	18.7305	18.5258
450213	17.7631	19.0651	18.5334	18.4589
450214	19.0475	20.5070	21.0485	20.1729
450217	12.8457	12.7647	13.1840	12.9276
450219	15.3976	17.6884	18.3602	17.1605
450221	16.3700	15.2120	16.1398	15.8866
450222	20.3129	19.8967	23.2779	21.1824
450224	24.9046	20.1579	16.2433	19.9276
450229	16.4503	16.7853	*	16.6236
450231	19.1564	19.1746	20.7709	19.7438
450234	16.1945	16.3003	16.5793	16.3818
450235	15.2332	16.3115	17.5349	16.3996
450236	16.6703	16.4957	17.0092	16.7226
450237	20.7930	19.0325	*	19.8837
450239	17.1308	17.8401	18.8416	17.9241
450241	12.5675	16.4240	16.6046	14.9426
450243	11.9099	13.6416	11.2035	12.2464
450246	16.5478	16.7959	22.7940	18.4445
450249	12.0302	11.7658	10.6467	11.4953
450250	10.2844	13.6787	*	11.6004
450253	12.2402	13.2177	14.5492	13.3367
450258	16.0466	16.7337	17.0724	16.6100
450264	13.8929	14.5956	17.2825	15.2193
450269	12.3594	12.7717	12.9555	12.7319
450270	12.8381	14.4792	13.6733	13.6110
450271	16.6319	16.7831	17.9808	17.1692
450272	19.9331	18.4344	20.5888	19.6562

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450276	13.1155	14.0745	14.0779	13.7681
450278	14.8291	15.2950	14.4871	14.8427
450280	22.2984	22.2936	20.3286	21.5973
450283	14.5664	15.1950	15.8684	15.2590
450288	16.2502	18.8935	13.5248	16.2231
450289	20.3104	20.3460	20.8745	20.5057
450292	16.9693	20.5335	17.7154	18.2921
450293	16.0132	16.2721	16.4077	16.2364
450296	21.6000	22.3430	*	21.9845
450299	21.5672	*	21.0398	21.2895
450303	12.4582	12.8996	14.3353	13.2442
450306	13.8216	14.2047	13.6333	13.8808
450307	16.4622	17.0691	17.6757	17.0817
450309	13.1480	13.3771	14.8823	13.8094
450315	22.8140	21.4684	23.8151	22.6579
450320	20.0946	20.6596	24.6129	21.4772
450321	13.1752	14.7344	14.4710	14.1070
450322	22.7667	29.1884	28.9834	26.4969
450324	17.7886	19.1692	20.9081	19.2343
450327	11.7511	13.3639	10.9732	11.8932
450330	18.9425	19.8066	20.8820	19.9093
450334	12.8051	13.8392	13.9839	13.5301
450337	17.1073	25.5708	*	20.0638
450340	17.6914	*	15.2368	16.4876
450341	18.9429	*	20.8814	19.8654
450346	17.5367	18.9475	19.2769	18.6527
450347	17.1099	19.3475	19.9109	18.7748
450348	13.9535	13.3585	15.0069	14.1063
450351	18.4116	19.3159	20.4537	19.4007
450352	18.7480	20.1871	21.2035	20.1227
450353	17.7539	16.0003	16.9105	16.8643
450355	11.9473	11.8933	12.8876	12.2285
450358	22.3235	23.0206	24.9765	23.4327
450362	15.8847	18.1983	18.1247	17.3786
450369	15.2233	15.3122	16.0667	15.5405
450370	12.6061	16.1369	18.7539	15.9177
450371	24.6339	16.0236	17.7591	19.2388
450372	20.0924	22.0746	21.4050	21.1434
450373	17.4183	17.9554	17.5600	17.6501
450374	13.6099	15.1750	15.0146	14.5995
450378	23.5789	23.4599	24.4143	23.8974
450379	22.7632	22.8756	25.1931	23.6182
450381	16.4166	16.7112	16.6476	16.5958
450388	19.2499	19.7408	20.6670	19.9390
450389	18.1797	18.8448	19.3156	18.7899
450393	20.2784	22.4992	21.1805	21.2450
450395	18.3768	18.0024	17.5236	17.9433
450399	15.7845	15.3491	16.3333	15.8319
450400	19.5379	18.6668	18.8375	18.9844
450403	20.1989	22.8430	24.7645	22.7028
450411	14.4832	15.1121	15.9178	15.1698
450417	13.4983	15.3591	15.2713	14.6933
450418	21.9161	21.9690	22.2511	22.0447
450419	20.6325	23.2551	22.4552	22.1296
450422	26.4848	28.0257	28.0395	27.5279
450423	22.7132	*	*	22.7132
450424	18.9741	18.7895	*	18.8834
450429	13.8723	*	*	13.8723
450431	19.6304	22.0361	21.7369	21.1141
450438	19.5028	15.4553	20.7791	18.3025
450446	13.0986	20.7592	*	16.2045
450447	18.0376	18.0377	19.3864	18.4641
450451	18.8948	18.2988	17.7525	18.2807

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450457	24.7880	19.6569	*	21.9578
450460	15.1765	14.6523	15.8434	15.2180
450462	22.6212	22.1144	18.6080	21.0035
450464	13.2931	15.5908	15.8121	14.8193
450465	15.5650	15.4731	19.3928	16.5297
450467	10.6184	17.0004	18.9388	14.4801
450469	19.6269	22.1930	22.0389	21.2453
450473	19.9761	19.7148	18.3813	19.2637
450475	16.3404	16.9269	19.0010	17.4228
450484	16.8131	18.9825	19.2310	18.3714
450488	19.3457	19.2173	21.5440	20.0301
450489	9.9326	16.3584	17.8779	13.9861
450497	15.0886	16.2997	15.9325	15.7828
450498	13.8551	14.4713	15.9479	14.7991
450508	18.8069	19.0991	19.2176	19.0434
450514	21.3243	20.0144	20.7064	20.6957
450517	27.8815	14.3191	17.6011	18.7482
450518	19.8116	21.4873	20.7355	20.6380
450523	20.0792	21.0393	20.8469	20.6355
450530	22.8623	21.1634	22.0810	22.0042
450534	19.9376	20.1520	19.7227	19.9301
450535	19.6645	21.0513	21.5449	20.7286
450537	20.8438	20.1161	20.6100	20.5223
450539	16.4921	18.7559	19.3681	18.2066
450544	23.9283	23.6652	22.7282	23.5339
450545	19.5558	20.2823	21.0792	20.2860
450547	14.8248	18.1524	19.3002	17.4255
450551	16.9439	16.6237	16.1437	16.5621
450558	22.2574	20.7404	21.3116	21.4292
450563	19.9218	22.0708	21.8171	21.3374
450565	16.2652	17.3803	17.8058	17.1566
450570	18.9532	19.0336	*	18.9910
450571	17.5598	18.2784	19.5325	18.4467
450573	12.2502	17.3518	17.5455	15.5608
450574	14.5965	14.6128	14.8549	14.6891
450575	19.3925	22.5621	24.0386	22.1410
450578	15.4783	18.0925	17.2863	16.9084
450580	15.8321	16.7374	17.8552	16.8065
450583	15.6580	14.4411	15.1202	15.0631
450584	14.2321	14.6735	14.9237	14.6266
450586	14.3773	13.8248	15.2831	14.4737
450587	17.0230	18.0219	17.6291	17.5412
450591	17.8981	17.7795	18.6275	18.1113
450596	22.5420	21.6729	21.9445	22.0245
450597	17.0776	17.6179	19.0641	17.9259
450603	11.6442	23.5572	23.4924	18.9348
450604	16.4535	17.6582	18.6241	17.5848
450605	21.1400	19.4580	19.7400	20.0918
450609	15.9753	17.0986	14.1776	15.7466
450610	18.9924	21.5191	22.1792	21.1877
450614	17.9853	16.5754	*	17.2230
450615	14.8562	15.2956	14.9323	15.0244
450617	20.3387	20.8919	21.5004	20.9383
450620	15.8380	16.0987	16.1315	16.0378
450623	22.1950	23.1270	25.1122	23.4424
450626	18.1673	18.4349	20.5225	19.1158
450628	20.5611	18.6093	19.9760	19.7367
450630	21.6876	20.9605	23.1840	21.9334
450631	20.0417	21.6736	21.7853	21.1405
450632	11.7587	13.9147	15.1416	13.5343
450633	19.5183	19.4949	*	19.5064
450634	23.5333	22.9877	23.0470	23.1838
450638	23.1437	22.1704	23.8335	23.0423

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450639	23.1936	21.6421	22.5182	22.4301
450641	16.5125	15.7578	15.1716	15.8348
450643	18.7054	16.8152	18.9088	18.1638
450644	23.6587	22.7721	24.5834	23.7084
450646	19.8274	19.1433	22.5667	20.4055
450647	24.7981	24.2763	25.0549	24.7111
450648	14.8488	15.0305	14.1565	14.6469
450649	16.4496	16.6577	16.7303	16.6187
450651	22.7664	22.7112	25.4679	23.6985
450652	13.4389	17.2445	*	14.7103
450653	18.1834	19.2349	19.5306	18.9413
450654	14.5258	14.5423	15.5858	14.8899
450656	17.6723	18.2606	18.5874	18.1828
450658	16.2657	17.2630	*	16.7212
450659	22.2550	23.0108	22.9344	22.7256
450661	19.7160	18.9071	19.5504	19.3935
450662	18.2284	19.3152	20.7973	19.5367
450665	15.2015	16.1319	14.2377	15.2093
450666	20.3248	20.2549	*	20.2912
450668	20.6965	21.0972	21.2002	20.9938
450669	21.7632	21.6746	22.5150	22.0051
450670	16.8893	20.2632	26.0785	20.9643
450672	21.8559	21.4927	23.2623	22.2025
450673	13.9620	13.7005	14.5310	14.0919
450674	22.2796	22.2426	21.9624	22.1483
450675	22.4961	21.4479	23.3954	22.4703
450677	22.6839	20.6556	21.3718	21.5395
450678	23.2617	24.1301	25.1841	24.1797
450683	20.9143	22.8699	21.9705	21.8695
450684	19.7005	21.9962	22.2380	21.3152
450686	16.5661	16.4632	17.4746	16.8354
450688	19.6250	20.1831	21.7691	20.5644
450690	21.6578	22.4707	27.2399	23.4791
450694	17.4758	18.1872	18.5520	18.0935
450696	24.9636	*	*	24.9636
450697	18.8405	19.4949	19.4424	19.2742
450698	14.6680	15.4750	16.5111	15.5420
450700	14.6421	15.9050	13.9129	14.8191
450702	20.8223	21.3739	19.3495	20.4688
450704	20.9821	20.7987	18.1835	19.7101
450705	30.0116	22.1809	18.7138	22.5666
450706	21.2072	22.0884	22.4329	21.9400
450709	20.8889	22.1490	21.9270	21.6715
450711	19.8126	19.8581	21.0779	20.2689
450712	13.6240	15.9298	11.7861	13.6660
450713	20.8065	22.6986	23.6017	22.4678
450715	22.0413	22.5988	24.8068	23.2060
450716	20.5544	20.9074	20.8913	20.7944
450717	20.7192	20.6551	22.0243	21.1286
450718	19.6886	22.1765	22.9582	21.6590
450723	19.7563	20.8213	22.1695	20.9457
450724	20.3235	20.3706	23.4039	21.3348
450727	13.5458	17.9172	24.7672	17.9685
450728	17.5284	19.8879	14.8030	17.2831
450730	22.0819	23.0054	24.5952	23.2900
450733	20.7693	20.2199	21.6162	20.8632
450735	13.8767	*	*	13.8767
450742	22.7655	21.8392	22.8135	22.4714
450743	18.8937	19.6015	20.5017	19.6892
450746	12.7904	30.2657	*	19.3854
450747	19.2585	20.3914	19.9818	19.8850
450749	16.2130	19.1678	17.2391	17.6065
450750	14.6914	13.8098	*	14.2686

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
450751	21.2198	19.9995	19.8170	20.4240
450754	16.0860	16.7145	16.7688	16.5644
450755	17.9904	19.8743	19.5916	19.1939
450757	13.8675	14.9434	15.5327	14.7530
450758	21.8669	19.0221	22.6196	21.1578
450760	17.4852	19.2225	20.4209	19.0477
450761	13.6152	15.7681	14.6511	14.6112
450763	18.2123	18.6092	18.9713	18.6032
450766	22.4348	23.3879	25.4057	23.7704
450769	14.5858	18.4163	17.3037	16.4629
450770	16.5458	19.0183	19.2518	18.2668
450771	22.4542	21.8268	21.4199	21.8514
450774	17.9964	16.2948	*	17.1404
450775	19.8897	21.3504	22.6526	21.2920
450776	15.7750	14.1720	13.4287	14.1843
450777	21.0682	19.0380	18.3119	19.5171
450779	21.4546	21.6642	22.1453	21.7809
450780	19.1498	19.0914	20.0824	19.4503
450785	18.4976	*	*	18.4976
450788	19.1463	19.6469	19.9597	19.6478
450794	18.2229	*	*	18.2229
450795	16.6494	22.5753	27.0250	21.6046
450796	16.5362	19.2059	*	17.7667
450797	15.9188	16.4923	20.2356	17.4420
450798	9.4634	*	*	9.4634
450801	17.5669	17.9548	17.9759	17.8371
450802	19.9168	17.1435	18.2460	18.3472
450803	18.3767	21.6653	*	20.6031
450804	19.4846	19.0893	20.5225	19.7061
450806	*	*	18.8211	18.8211
450807	11.3192	13.4306	18.4410	13.7054
450808	16.9915	17.4917	18.1728	17.5602
450809	20.0202	19.7899	21.8610	20.5411
450811	19.0961	19.9168	21.6115	20.3503
450813	15.9166	14.5392	15.3780	15.2272
450815	*	21.2741	*	21.2741
450819	*	16.5521	*	16.5521
450820	*	26.8348	24.6742	25.7177
450822	*	22.8556	24.8702	23.9136
450823	*	*	17.9756	17.9756
450824	*	*	25.7488	25.7488
450825	*	*	15.3546	15.3546
450827	*	*	20.1310	20.1310
450828	*	*	17.7667	17.7667
450829	*	*	14.7121	14.7121
460001	21.7996	22.2735	23.5485	22.5533
460003	20.0452	22.6289	*	21.2787
460004	21.3744	21.7234	23.1289	22.0969
460005	19.7069	22.5252	23.0189	21.6769
460006	20.6252	21.0700	22.1648	21.3374
460007	20.8026	21.1922	22.0409	21.4007
460008	18.8661	19.1153	22.6808	20.2069
460009	21.9016	22.5295	23.1146	22.5111
460010	21.9830	22.4948	23.8996	22.8204
460011	18.8660	19.7674	24.6789	20.7963
460013	20.7326	20.1936	*	20.4776
460014	18.3865	18.5370	*	18.4531
460015	20.6593	21.0470	22.4872	21.4209
460016	18.2408	21.9105	19.0910	19.6368
460017	17.7103	18.9929	*	18.3294
460018	17.6235	17.0063	17.0385	17.1969
460019	16.2671	17.8690	19.3442	17.7589
460020	17.3467	17.2663	18.1542	17.5580

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
460021	21.0470	21.5174	23.1368	21.9697
460022	20.1534	21.3614	20.7539	20.7266
460023	22.3535	22.9265	24.1825	23.1937
460025	19.4247	17.3494	17.4070	17.9267
460026	19.9241	20.2576	21.1759	20.4671
460027	21.8868	22.2955	21.4833	21.8607
460029	20.5154	20.8366	22.7658	21.3471
460030	17.6071	17.1383	18.1423	17.6207
460032	21.1006	21.4832	21.0286	21.1954
460033	19.5372	19.2664	20.2389	19.6949
460035	16.0021	16.1685	15.6979	15.9450
460036	23.5893	23.4573	24.2651	23.7927
460037	18.6850	17.7399	19.0115	18.4898
460039	24.9134	24.4808	24.5134	24.6186
460041	21.0623	20.2035	21.6676	20.9770
460042	18.8814	19.5662	20.9858	19.8725
460043	24.4779	23.2819	25.1366	24.2896
460044	21.4696	21.8485	23.6604	22.3504
460046	18.2224	*	*	18.2224
460047	23.0433	22.7524	23.4965	23.0972
460049	19.6483	20.8283	21.5241	20.8906
460051	19.4761	22.1758	21.8595	21.1765
460052	*	19.8961	20.1989	20.0325
470001	20.2299	21.3817	21.7774	21.1523
470003	23.6949	22.0563	23.4163	23.0458
470004	16.8842	18.1879	17.3576	17.4706
470005	21.9191	23.1808	22.6589	22.5826
470006	17.8699	20.2829	21.0835	19.7003
470008	19.6069	20.1969	20.3833	20.0728
470010	20.2961	21.0616	22.3913	21.2927
470011	21.7675	22.2415	24.1306	22.7075
470012	18.5339	18.9444	19.8831	19.1162
470015	19.5366	20.2125	21.8204	20.4728
470018	21.5426	21.2406	23.1159	21.9638
470020	20.6643	21.5688	21.9911	21.4308
470023	20.4511	21.7139	22.5334	21.5811
470024	20.8510	21.9807	23.2738	22.0567
490001	21.9755	20.0570	21.4952	21.1603
490002	15.2287	15.7365	16.5198	15.8281
490003	19.1040	20.3237	20.7688	20.0621
490004	19.2126	19.7074	20.7390	19.8866
490005	20.5517	21.3318	22.9490	21.6702
490006	15.9537	12.3253	19.8977	16.1242
490007	18.7740	19.8938	20.5265	19.7370
490009	23.9344	23.7659	24.7602	24.1271
490010	21.7424	*	*	21.7424
490011	18.6071	19.8042	19.8179	19.3919
490012	15.9973	15.2965	16.0994	15.7867
490013	17.3318	18.2396	18.3901	17.9911
490014	25.8315	23.5266	27.8907	25.6619
490015	19.6363	20.0667	21.4500	20.3969
490017	18.4361	19.3854	*	18.9126
490018	18.3435	18.5508	19.7456	18.8862
490019	19.6178	21.0124	21.6790	20.8153
490020	18.5691	19.3424	20.9212	19.6001
490021	19.3945	20.0496	21.2263	20.2509
490022	21.2183	22.3380	24.3008	22.6504
490023	20.6694	21.5683	22.8400	21.7338
490024	17.7221	18.4314	19.7501	18.7524
490027	16.2761	16.7556	17.5178	16.8693
490030	9.1789	8.6446	*	8.9749
490031	14.9539	16.0003	17.4262	16.1268
490032	22.4262	21.4037	22.2041	22.0055

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
490033	21.1723	19.2908	24.3589	21.5324
490037	16.3759	17.0113	16.7752	16.7116
490038	21.0218	17.6324	18.6012	18.9881
490040	22.7061	24.1266	24.8808	23.9273
490041	18.3589	18.7987	17.9942	18.3695
490042	16.4666	17.0972	18.1733	17.2802
490043	22.1574	22.1068	24.0198	22.7114
490044	18.3137	19.7842	18.4845	18.8757
490045	20.5468	20.5558	21.8453	21.0100
490046	18.4825	19.9102	19.7466	19.3960
490047	25.0438	18.7614	20.0837	20.6715
490048	18.4361	19.5417	20.9110	19.5970
490050	23.0729	23.3668	23.8519	23.4357
490052	16.8600	16.4787	17.6096	16.9745
490053	15.6996	16.8410	17.7363	16.7991
490054	15.4734	19.5780	22.5136	19.1813
490057	19.9210	20.3160	20.7806	20.3441
490059	20.8662	21.4801	24.1516	22.0719
490060	17.6308	18.5917	19.3525	18.5249
490063	28.6536	26.1930	*	27.3515
490066	20.6972	19.8352	21.5920	20.7067
490067	17.0195	17.8487	18.6469	17.8519
490069	17.3297	20.7582	21.5228	19.7588
490071	21.8879	23.3511	23.9246	23.0331
490073	20.7960	26.0957	*	23.1759
490075	18.6983	19.2156	20.2001	19.3654
490077	21.3670	22.6504	22.4133	22.1262
490079	17.0815	17.7016	17.5839	17.4571
490084	16.7834	18.0555	18.9679	17.9259
490085	17.4584	17.6158	19.2494	18.1150
490088	16.4362	17.9141	19.1415	17.7397
490089	17.7692	18.2290	19.6501	18.5835
490090	17.0199	17.5799	19.2094	17.9357
490091	20.8734	25.0272	23.6634	22.9282
490092	16.9533	16.4360	*	16.7160
490093	17.3711	17.8275	18.9442	18.0549
490094	18.9204	22.3033	20.2020	20.4445
490097	15.5780	16.9518	16.1076	16.1614
490098	15.1403	16.0488	18.5355	16.5130
490099	17.9665	18.3985	19.2604	18.5294
490100	22.5010	*	*	22.5010
490101	24.7616	23.5553	25.7804	24.7017
490104	25.6889	40.2529	*	29.6601
490105	18.5765	21.4428	*	19.7749
490106	17.6596	26.3821	31.8566	22.3213
490107	23.5240	22.9283	23.9962	23.5071
490108	20.2112	24.1232	24.8596	22.6562
490109	23.6620	25.9475	23.0609	24.1978
490110	16.5131	18.1561	18.8042	17.8380
490111	17.1768	17.8510	19.6489	18.2093
490112	21.4532	22.1162	23.2843	22.3013
490113	23.2235	23.9043	26.1840	24.4577
490114	17.3047	18.0359	18.8920	18.0825
490115	16.5203	16.8537	18.4499	17.2731
490116	16.6170	17.2040	18.2935	17.3997
490117	14.0104	14.7944	15.9284	14.9234
490118	21.4674	23.2022	24.2668	22.9444
490119	17.9147	18.6046	18.9640	18.4840
490120	19.3707	20.5777	20.4547	20.1460
490122	23.8801	23.8198	26.6681	24.7636
490123	17.7461	19.3056	20.0920	19.0902
490124	22.0884	21.3818	23.6526	22.4301
490126	18.6844	20.4294	19.0782	19.3248

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
490127	16.0516	16.5993	17.6437	16.7293
490129	22.5885	28.6868	*	23.5799
490130	16.4322	17.6943	18.6406	17.5834
490132	18.6570	18.4671	19.1742	18.7508
500001	22.1896	24.4829	25.2411	23.9385
500002	21.6332	19.8476	22.9942	21.4749
500003	24.2814	24.4333	25.1200	24.6216
500005	22.3955	24.3870	26.6971	24.3513
500007	26.0599	21.9911	24.7889	24.1708
500008	25.3064	26.1737	27.2852	26.2556
500011	24.0162	24.6554	25.7263	24.7924
500012	20.7032	24.2799	24.5450	23.0771
500014	24.3419	24.0990	25.0490	24.4936
500015	23.9297	24.9923	25.8775	24.9616
500016	24.3938	24.9439	25.1227	24.8306
500019	22.4213	23.2054	23.5730	23.0604
500021	25.9198	27.6490	25.9403	26.4613
500023	26.6535	27.1025	32.3079	28.0325
500024	23.7472	26.6452	26.2113	25.5094
500025	26.4810	24.4825	27.2601	26.0674
500026	23.8005	26.9884	26.6108	25.7916
500027	22.2158	25.1125	27.5909	24.9753
500028	19.2675	18.9556	19.0261	19.0887
500029	17.9237	18.5042	19.3130	18.5707
500030	24.9039	26.3828	28.5297	26.6182
500031	29.2707	23.6099	25.8542	26.0586
500033	22.3527	22.5462	23.8994	22.9522
500036	22.1096	23.6333	25.1255	23.5838
500037	20.7139	21.4059	22.1774	21.4194
500039	23.8918	24.0007	25.4225	24.4379
500041	23.9608	25.4376	24.7070	24.7067
500042	22.9125	*	*	22.9125
500043	20.9459	22.0466	24.1745	22.4162
500044	23.3364	24.2212	24.7816	24.1154
500045	20.8881	24.0526	24.6265	23.0766
500048	22.1906	20.3207	20.6333	21.0462
500049	24.0489	24.5997	26.5857	25.0314
500050	22.0065	22.6563	23.0804	22.6053
500051	24.8203	25.9447	26.7628	25.8820
500053	23.9397	22.8399	24.2492	23.6675
500054	22.8829	23.8089	25.7815	24.1708
500055	23.7446	23.8622	23.7988	23.8022
500057	18.2737	19.0479	20.5812	19.3310
500058	24.7882	24.1106	26.5679	25.1920
500059	23.3506	26.6270	25.3528	25.0566
500060	25.0233	28.3655	29.6030	27.5162
500061	21.7013	20.8624	24.5908	22.4271
500062	18.6329	19.0557	19.1685	18.9583
500064	25.5748	26.7000	27.5791	26.6387
500065	21.9308	23.5671	24.0966	23.2140
500068	19.6574	19.2638	20.9278	19.9560
500069	21.3592	21.4542	22.4158	21.7566
500071	19.1906	19.1428	22.3253	20.1059
500072	25.3928	25.2001	25.7734	25.4637
500073	21.2469	21.7698	22.5222	21.8777
500074	18.9679	19.5981	20.6120	19.7482
500077	22.8536	23.9410	24.5407	23.7721
500079	24.2036	23.1041	24.7946	24.0303
500080	15.6630	18.3883	18.8188	17.4053
500084	23.4032	24.4044	24.5678	24.1531
500085	21.4403	20.4517	20.7422	20.8523
500086	23.3288	22.8829	24.2556	23.4907
500088	23.2701	25.2478	25.2774	24.5589

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
500089	18.7080	19.7166	20.3478	19.5281
500090	16.1576	20.4429	21.7716	18.7859
500092	16.7913	19.2028	20.3058	18.6898
500094	18.5835	15.7866	17.6625	17.4874
500096	21.0151	23.3564	25.1135	23.2107
500097	19.7706	20.8774	21.4423	20.6699
500098	16.3511	15.2040	13.5203	15.0572
500101	19.7337	15.8000	19.8614	18.4197
500102	20.9389	21.8963	23.1307	22.0050
500104	22.8154	24.9389	24.7875	24.1421
500106	18.6041	19.1465	17.1066	18.3020
500107	18.1201	17.9489	17.4641	17.8401
500108	26.2939	28.6229	26.1609	27.0259
500110	21.4553	22.9775	23.5941	22.6736
500118	23.8397	24.8034	24.7875	24.4924
500119	22.4373	22.1192	23.9939	22.8469
500122	22.4268	23.5264	24.4462	23.5112
500123	20.3181	19.6646	21.7133	20.7526
500124	23.2836	23.7742	24.6591	23.9700
500125	15.1112	14.7910	15.6304	15.1911
500129	26.1575	25.4685	25.2082	25.5438
500132	15.6717	23.1822	21.9915	20.2081
500134	17.7457	17.2430	15.9791	16.9729
500139	22.2297	22.3053	23.7993	22.7606
500141	23.8838	29.9695	28.1014	27.3199
500143	18.0343	18.2570	18.7523	18.3736
500146	21.6003	*	*	21.6003
510001	19.1492	20.0429	20.2514	19.8050
510002	20.1527	17.6392	19.1517	18.9313
510005	14.2503	13.8621	13.8641	13.9934
510006	18.7313	19.9609	19.9760	19.5653
510007	21.2729	21.6761	23.0072	22.0021
510008	18.3296	19.0513	20.1039	19.1754
510012	15.8390	15.6089	15.8596	15.7743
510013	17.8527	19.5798	18.3486	18.5734
510015	14.9039	16.7311	17.1595	16.3249
510018	18.5269	18.5358	18.3023	18.4548
510020	13.1837	14.1211	15.7512	14.3266
510022	20.1763	21.5770	21.4336	21.0418
510023	16.0129	16.7777	17.6516	16.8122
510024	19.0941	18.7461	19.6521	19.1601
510026	13.6888	13.7952	14.8785	14.0865
510027	17.2900	18.5945	20.5222	18.7968
510028	20.0628	19.9208	22.4826	20.8230
510029	17.7124	18.4668	16.3204	17.4181
510030	17.4198	17.7603	19.2558	18.1712
510031	28.6673	18.6341	19.3049	21.2106
510033	18.4082	18.4718	19.6900	18.8637
510035	16.5007	18.3164	21.7818	18.6703
510036	13.4559	13.8786	15.0266	14.0903
510038	15.8132	15.5576	15.9821	15.7873
510039	16.9398	17.1461	17.4002	17.1582
510043	14.0662	13.1308	14.4202	13.8751
510046	17.3821	18.5896	18.7424	18.2568
510047	19.8963	20.8101	21.2375	20.6123
510048	21.0407	17.1647	15.2886	17.8240
510050	16.9136	18.4036	18.3964	17.9380
510053	16.1036	17.5798	18.1046	17.2603
510055	23.7248	24.2133	25.6333	24.5104
510058	18.4156	18.4501	18.6025	18.4938
510059	16.5854	16.1044	17.3844	16.6208
510060	17.5594	*	*	17.5594
510061	13.8204	14.1968	14.6774	14.2360

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
510062	19.3881	18.1588	19.7964	19.0922
510066	12.2943	*	*	12.2943
510067	16.7161	17.3067	17.8816	17.3091
510068	18.7938	23.0452	19.4299	20.2577
510070	18.5146	18.7091	18.6226	18.6195
510071	17.2148	18.0278	18.8766	18.0317
510072	15.6262	15.9257	16.5279	16.0216
510077	18.0668	18.2947	20.4521	18.9028
510080	17.4485	16.3453	18.5318	17.3501
510081	13.6359	11.9701	10.4972	11.9879
510082	17.4538	13.5946	16.0014	15.5120
510084	17.2395	13.5339	14.9683	15.2567
510085	17.5624	18.6227	19.0175	18.4360
510086	13.4763	14.2241	16.3413	14.6710
510088	*	14.8854	16.2850	15.6272
520002	19.7447	19.6755	19.3159	19.5604
520003	17.1248	18.7956	18.7507	18.2896
520004	19.6512	20.4591	18.8843	19.6231
520006	21.5313	21.4884	22.4099	21.7879
520007	16.2001	18.4629	18.3959	17.6275
520008	22.8024	24.9395	24.4927	24.0917
520009	18.6002	21.4638	19.8142	19.9388
520010	22.7703	22.3311	25.4845	23.5468
520011	20.7410	21.5223	21.6945	21.3155
520013	20.3965	20.5944	22.1009	21.0588
520014	17.1646	18.0841	19.2760	18.1480
520015	18.6078	19.7672	21.0428	19.8323
520016	17.3018	18.4320	19.5656	18.4077
520017	19.6008	19.4780	21.1409	20.0934
520018	21.1941	21.5279	22.1929	21.6736
520019	19.5440	20.9164	21.8870	20.7980
520021	21.3471	21.9531	22.8484	22.1016
520024	14.0175	14.4750	16.4879	15.0572
520025	18.2430	20.3838	21.9529	20.1629
520026	21.5453	20.8546	22.7429	21.7237
520027	19.9324	21.5868	22.0947	21.2079
520028	21.2852	22.5941	22.0333	21.9368
520029	19.5750	21.4197	21.6729	20.8760
520030	20.5039	21.6311	22.7239	21.6241
520031	20.4814	20.9875	21.2809	20.8937
520032	19.5697	21.1069	24.1092	21.5816
520033	19.2954	20.2520	21.0088	20.1750
520034	17.1282	20.4307	21.2944	19.6400
520035	18.9452	18.7135	19.7990	19.1719
520037	20.6686	21.6017	23.0801	21.8015
520038	19.6294	20.6130	21.2769	20.4835
520039	20.7641	23.3687	21.8688	21.9128
520040	20.4677	21.2023	23.0710	21.5679
520041	17.1959	18.4117	17.6529	17.7461
520042	18.5843	19.5466	20.6354	19.6057
520044	18.4014	19.1877	21.4913	19.6621
520045	20.5917	21.2427	21.9812	21.2870
520047	18.3048	20.3487	21.0370	19.8304
520048	20.6583	19.8926	20.3488	20.2938
520049	20.3559	20.1667	21.8271	20.7868
520051	21.6497	24.0460	23.4366	23.0036
520053	17.3945	18.0851	18.7234	18.0684
520054	15.1747	16.8363	16.6278	16.1750
520057	19.0872	19.8492	20.6959	19.9036
520058	19.7283	21.2500	23.6794	21.5351
520059	20.9913	21.5796	21.9452	21.5150
520060	17.9258	18.8232	20.3357	19.0291
520062	19.1482	19.7038	21.5525	20.1564

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
520063	19.6136	20.5262	21.2774	20.4843
520064	22.7423	22.0917	23.7144	22.8379
520066	22.8837	24.0087	24.1733	23.6290
520068	18.9943	19.6855	19.9595	19.5384
520069	20.2934	20.1770	21.7233	20.5221
520070	18.5938	19.4261	20.0096	19.3562
520071	18.7304	19.9866	22.0066	20.1801
520074	20.4601	20.9007	21.6636	20.9770
520075	19.8457	20.7301	22.1894	20.9388
520076	17.6088	19.5878	20.6155	19.2421
520077	17.7830	18.7119	18.1077	18.2004
520078	21.3380	21.7545	20.5734	21.2201
520082	17.7405	*	*	17.7405
520083	23.8849	23.5787	24.2131	23.8898
520084	20.8427	23.5446	21.8102	22.0208
520087	20.3624	20.7821	22.2579	21.1364
520088	20.6312	21.8931	22.3921	21.5920
520089	21.5456	22.1055	23.1221	22.2509
520090	18.9343	20.3645	20.9069	20.0854
520091	20.9927	20.9440	22.2218	21.3884
520092	17.6500	18.6248	19.7870	18.7181
520094	20.3611	20.6179	21.3082	20.7652
520095	20.3269	18.6425	21.8172	20.1804
520096	19.7757	20.6668	21.6803	20.7358
520097	20.2354	20.8016	22.2375	21.1096
520098	22.3348	23.4707	23.4273	23.0928
520100	18.3832	19.4788	20.5366	19.4712
520101	19.5186	19.9875	20.0164	19.8451
520102	20.1898	21.0138	22.1413	21.1139
520103	19.4809	20.1092	22.2765	20.6137
520107	20.3747	21.7907	23.8421	21.9354
520109	19.1303	19.7609	20.3208	19.7432
520110	20.4494	21.0055	22.3923	21.3276
520111	17.7834	17.7673	18.2744	17.9282
520112	19.1797	18.9577	17.6226	18.3876
520113	21.1485	21.8852	23.1852	22.0983
520114	16.6616	17.8476	18.5767	17.6415
520115	18.2980	19.2248	21.4279	19.6231
520116	19.8509	20.6922	22.2741	20.9026
520117	18.5414	18.3963	19.3653	18.7838
520118	14.2326	14.8626	13.9920	14.3519
520120	18.7437	*	*	18.7437
520121	19.7305	20.8492	20.9422	20.5799
520122	16.2436	16.9335	16.9905	16.7143
520123	17.3980	17.7986	19.8134	18.4575
520124	17.2619	17.9205	19.2621	18.1369
520130	15.6845	16.6873	18.8845	17.0161
520131	18.7295	20.2591	21.0400	20.0321
520132	15.6379	18.1630	18.2634	17.2681
520134	18.0953	18.8150	19.6881	18.8725
520135	15.8246	17.3476	18.1026	17.0799
520136	19.8480	20.9050	21.3966	20.7380
520138	21.2260	22.5599	22.5773	22.1218
520139	20.9988	21.4042	22.8070	21.7325
520140	21.5207	22.3671	22.5459	22.1346
520142	20.5858	21.9432	21.4120	21.2420
520144	18.5701	19.9120	20.5864	19.6719
520145	18.2654	18.7958	20.3461	19.0923
520146	17.9585	18.2370	18.6337	18.2882
520148	17.2421	19.1502	20.5075	19.0048
520149	14.1901	12.8928	13.8614	13.6192
520151	17.3267	18.7070	19.3362	18.4627
520152	19.5858	22.5980	26.2402	22.5080

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA) AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly** wage (3 yrs)
520153	15.9753	17.0863	18.3447	17.1026
520154	18.5403	19.5994	21.0486	19.7479
520156	21.3377	20.9638	20.7806	21.0121
520157	17.1974	19.6008	21.6821	19.4299
520159	18.6760	17.7649	21.8783	19.4305
520160	19.4173	20.5154	21.5266	20.5092
520161	19.4905	20.1102	21.4038	20.3456
520170	21.5233	21.9857	23.0867	22.2181
520171	17.4560	18.0785	18.1844	17.8993
520173	21.3016	20.9209	23.2955	21.8315
520177	22.7221	24.0139	25.1080	23.8746
520178	18.6936	20.9010	23.1509	20.7167
520188	13.9135	*	*	13.9135
520189	*	*	21.6813	21.6813
530002	19.3273	21.0560	23.0582	21.0877
530003	16.2139	15.9523	17.1646	16.4518
530004	15.0497	13.3788	17.4672	15.2335
530005	13.3529	15.3255	18.3704	15.7393
530006	18.5894	19.1305	20.7661	19.4956
530007	18.5161	17.7897	18.5286	18.3005
530008	18.8349	19.0113	19.0016	18.9483
530009	22.5009	21.7795	23.5839	22.6178
530010	21.6092	13.9536	12.3695	15.3501
530011	18.7354	19.4606	19.9212	19.3808
530012	18.9923	21.1854	22.5084	20.9252
530014	18.0869	18.4900	20.0422	18.9065
530015	22.4568	23.4040	24.6527	23.4897
530016	18.1562	19.3205	20.3647	19.2610
530017	16.3478	17.7736	20.9408	18.2556
530018	18.3783	19.5986	20.1226	19.3605
530019	18.5430	20.1097	18.1492	18.8643
530022	18.5002	19.6136	19.7902	19.3159
530023	20.1948	20.0677	21.6352	20.6416
530025	21.2598	22.0300	22.4816	21.9309
530026	17.0118	19.8969	20.9919	19.1178
530027	18.1664	25.5067	*	20.8124
530029	16.5092	19.3361	20.3046	18.6145
530031	18.3322	20.1734	23.2766	20.4477
530032	21.0361	20.0132	20.9856	20.6817

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Abilene, TX	21.3116	18.2370
Aguadilla, PR	10.6548	10.3692
Akron, OH	22.2695	21.8175
Albany, GA	24.9139	23.4370
Albany-Schenectady-Troy, NY	19.4516	19.0017
Albuquerque, NM	21.3374	20.9862
Alexandria, LA	18.1736	17.9283
Allentown-Bethlehem-Easton, PA	22.6105	22.2137

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Altoona, PA	21.3848	20.7048
Amarillo, TX	20.8120	19.7427
Anchorage, AK	28.6899	28.2057
Ann Arbor, MI	25.7925	25.0051
Anniston, AL	18.6862	18.3987
Appleton-Oshkosh-Neenah, WI	20.8773	20.4112
Arecibo, PR	10.0744	10.0865
Asheville, NC	22.2638	21.2069
Athens, GA	23.7041	22.3198
Atlanta, GA	23.2034	22.5565

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Atlantic-Cape May, NJ	25.4286	24.9782
Auburn-Opelika, AL	19.1001	18.3671
Augusta-Aiken, GA-SC	23.8329	21.9394
Austin-San Marcos, TX	21.9115	21.4039
Bakersfield, CA	23.4741	21.9163
Baltimore, MD	22.4354	21.6104
Bangor, ME	22.5137	21.5643
Barnstable-Yarmouth, MA	30.1848	30.2355

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Baton Rouge, LA	19.2871	18.9071
Beaumont-Port Arthur, TX	19.2896	19.0451
Bellingham, WA	28.5297	26.6182
Benton Harbor, MI	20.6766	19.7627
Bergen-Passaic, NJ	27.8231	26.5455
Billings, MT	20.9586	20.9004
Biloxi-Gulfport-Pascagoula, MS	20.3045	19.0487
Binghamton, NY	19.3760	19.0441
Birmingham, AL	21.3884	19.7545
Bismarck, ND	18.0466	17.5136
Bloomington,IN	20.6895	19.8190
Bloomington-Normal, IL	21.1609	20.3703
Boise City, ID	21.6225	20.5010
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	25.9941	25.2200
Boulder-Longmont, CO	22.2777	21.7937
Brazoria, TX	19.8139	19.0124
Bremerton, WA	25.4225	24.4379
Brownsville-Harlingen-San Benito, TX	20.6770	19.9443
Bryan-College Station, TX	19.3399	19.2454
Buffalo-Niagara Falls, NY	21.7624	21.2368
Burlington, VT	23.3989	22.9310
Caguas, PR	10.1529	10.1915
Canton-Massillon, OH	20.7556	19.7901
Casper, WY	22.5084	20.9252
Cedar Rapids, IA	21.0377	19.8268
Champaign-Urbana, IL	22.9565	20.9245
Charleston-North Charleston, SC	18.6257	19.5755
Charleston, WV	20.1558	20.3125
Charlotte-Gastonia-Rock Hill, NC-SC	22.6242	21.3014
Charlottesville, VA	24.3357	23.7751
Chattanooga, TN-GA	20.8534	21.0504
Cheyenne, WY	20.0422	18.9065
Chicago, IL	25.4960	24.8000
Chico-Paradise, CA	22.6186	22.0636
Cincinnati, OH-KY-IN	21.4375	21.0209
Clarksville-Hopkinsville, TN-KY	19.2844	18.5774
Cleveland-Lorain-Elyria, OH	21.3730	21.1174
Colorado Springs, CO	22.9223	21.9346
Columbia, MO	20.0916	19.6531
Columbia, SC	20.6722	20.8728
Columbus, GA-AL	19.4319	18.9760
Columbus, OH	22.3157	21.5032
Corpus Christi, TX	18.7495	18.7846
Corvallis, OR	26.6038	25.7705
Cumberland, MD-WV	18.2292	18.3160
Dallas, TX	22.6072	22.1220
Danville, VA	20.2001	19.3654

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Davenport-Moline-Rock Island, IA-IL	20.4000	19.6921
Dayton-Springfield, OH	21.5652	20.8876
Daytona Beach, FL	21.0017	20.3557
Decatur, AL	20.8473	19.7262
Decatur, IL	18.5380	18.0259
Denver, CO	23.9179	23.0032
Des Moines, IA	20.3902	19.9395
Detroit, MI	24.1574	23.4668
Dothan, AL	18.3729	17.7890
Dover, DE	21.7344	22.1849
Dubuque, IA	20.2381	19.4209
Duluth-Superior, MN-WI	24.0567	22.9550
Dutchess County, NY	24.8186	23.5537
Eau Claire, WI	20.7890	19.9433
El Paso, TX	21.0095	20.6428
Elkhart-Goshen, IN	22.6528	21.3565
Elmira, NY	19.7114	19.0237
Enid, OK	19.2869	18.8881
Erie, PA	20.7316	19.9094
Eugene-Springfield, OR	25.4725	24.9448
Evansville, Henderson, IN-KY	18.9808	18.5894
Fargo-Moorhead, ND-MN	22.4962	20.6192
Fayetteville, NC	20.6496	19.8938
Fayetteville-Springdale-Rogers, AR	18.8149	18.2982
Flagstaff, AZ-UT	24.8141	23.9367
Flint, MI	25.8296	24.8385
Florence, AL	18.2288	17.4228
Florence, SC	20.3953	19.6524
Fort Collins-Loveland, CO	22.8171	22.8018
Fort Lauderdale, FL	23.8406	22.9502
Fort Myers-Cape Coral, FL	21.7431	20.9253
Fort Pierce-Port St. Lucie, FL	22.5387	22.0206
Fort Smith, AR-OK	17.9611	17.8193
Fort Walton Beach, FL	22.1915	21.0734
Fort Wayne, IN	21.8421	20.4123
Fort Worth-Arlington, TX	22.1218	21.2887
Fresno, CA	23.7765	22.6843
Gadsden, AL	19.7302	19.2011
Gainesville, FL	22.3748	21.8054
Galveston-Texas City, TX	22.0810	22.2390
Gary, IN	22.2500	21.3750
Glens Falls, NY	19.1071	18.6348
Goldsboro, NC	20.6547	19.5049
Grand Forks, ND-MN	20.6675	19.9946
Grand Junction, CO	22.1097	21.1165
Grand Rapids-Muskegon-Holland, MI	22.1795	22.3013
Great Falls, MT	20.7913	20.0975
Greeley, CO	20.6781	21.0801
Green Bay, WI	22.0738	20.9151

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Greensboro-Winston-Salem-High Point, NC	21.3171	20.8100
Greenville, NC	21.1020	20.7582
Greenville-Spartanburg-Anderson, SC	21.1013	20.4227
Hagerstown, MD	21.5280	20.1745
Hamilton-Middletown, OH	21.8081	20.7774
Harrisburg-Lebanon-Carlisle, PA	21.4204	21.2190
Hartford, CT	26.5589	25.6600
Hattiesburg, MS	17.6308	16.8808
Hickory-Morganton-Lenoir, NC	20.5993	20.3564
Honolulu, HI	25.5733	25.7139
Houma, LA	19.4770	18.2833
Houston, TX	22.4099	21.6980
Huntington-Ashland, WV-KY-OH	22.4054	21.7937
Huntsville, AL	20.4686	19.9112
Indianapolis, IN	22.6001	21.8532
Iowa City, IA	23.0524	21.9952
Jackson, MI	22.0543	20.8972
Jackson, MS	20.0348	19.3281
Jackson, TN	21.5461	20.3227
Jacksonville, FL	21.4789	20.7080
Jacksonville, NC	19.1386	17.6977
Jamestown, NY	18.5184	17.7951
Janesville-Beloit, WI	22.2956	21.6016
Jersey City, NJ	25.7550	25.2422
Johnson City-Kingsport-Bristol, TN-VA	19.1020	18.7739
Johnstown, PA	19.3481	19.3567
Jonesboro, AR	18.0006	17.9165
Joplin, MO	20.0064	19.0676
Kalamazoo-Battlecreek, MI	24.5797	23.6868
Kankakee, IL	22.0535	21.8916
Kansas City, KS-MO	22.5556	21.5044
Kenosha, WI	22.3994	21.6107
Killeen-Temple, TX	19.4230	20.6248
Knoxville, TN	20.9030	19.6266
Kokomo, IN	20.5813	20.5547
La Crosse, WI-MN	20.9920	20.5609
Lafayette, LA	19.6610	19.0691
Lafayette, IN	21.8803	20.4752
Lake Charles, LA	18.4643	17.2545
Lakeland-Winter Haven, FL	21.0679	20.4786
Lancaster, PA	21.0878	20.6617
Lansing-East Lansing, MI	22.5979	21.9294
Laredo, TX	19.5558	18.3090
Las Cruces, NM	20.4375	19.5136
Las Vegas, NV-AZ	25.3348	24.6305
[1] Lawrence, KS	.....	17.8290
Lawton, OK	18.9728	19.3040
Lewiston-Auburn, ME	21.2671	20.5697
Lexington, KY	19.8413	19.5837
Lima, OH	21.8791	21.1154
Lincoln, NE	20.5292	21.3398

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Little Rock-North Little Rock, AR	20.7992	19.9953
Longview-Marshall, TX	19.7471	19.4279
Los Angeles-Long Beach, CA	27.6569	26.7968
Louisville, KY-IN	21.8834	21.1577
Lubbock, TX	17.7930	18.8697
Lynchburg, VA	21.4112	20.3454
Macon, GA	21.2905	20.2752
Madison, WI	23.4267	22.9567
Mansfield, OH	20.6712	19.6802
Mayaguez, PR	11.3157	10.6879
McAllen-Edinburg-Mission, TX	19.3599	18.9086
Medford-Ashland, OR	24.3865	23.3354
Melbourne-Titusville-Palm Bay, FL	24.7923	22.7180
Memphis, TN-AR-MS	20.3251	19.7569
Merced, CA	22.8511	21.9541
Miami, FL	22.6833	22.2549
Middlesex-Somerset-Hunterdon, NJ	26.3374	25.3182
Milwaukee-Waukesha, WI	22.7676	22.0856
Minneapolis-St. Paul, MN-WI	25.2239	24.5477
Missoula, MT	21.2713	20.8023
Mobile, AL	18.8082	18.2018
Modesto, CA	24.3874	23.6713
Monmouth-Ocean, NJ	25.9158	24.8978
Monroe, LA	18.8342	18.4736
Montgomery, AL	17.8451	16.9642
Muncie, IN	21.0399	22.2998
Myrtle Beach, SC	21.0194	19.6847
Naples, FL	22.5429	21.7594
Nashville, TN	21.7439	21.3869
Nassau-Suffolk, NY	30.9070	30.5534
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	28.6474	27.5560
New London-Norwich, CT	27.2742	26.4332
New Orleans, LA	20.8098	20.4020
New York, NY	32.3513	32.1379
Newark, NJ	26.4531	26.0261
Newburgh, NY-PA	26.2921	24.9278
Norfolk-Virginia Beach-Newport News, VA-NC	19.6667	19.0225
Oakland, CA	35.0027	33.9458
Ocala, FL	21.9054	21.0412
Odessa-Midland, TX	21.2320	21.2696
Oklahoma City, OK	20.6894	19.7355
Olympia, WA	25.4588	24.6677
Omaha, NE-IA	23.1988	21.8834
Orange County, CA	26.6831	25.4624
Orlando, FL	21.9294	21.4758
Owensboro, KY	19.0457	18.4790
Panama City, FL	20.5244	20.1345
Parkersburg-Marietta, WV-OH	18.8778	18.3560
Pensacola, FL	19.9673	18.7468
Peoria-Pekin, IL	20.3592	19.5705
Philadelphia, PA-NJ	24.5469	24.2416
Phoenix-Mesa, AZ	21.9868	21.5339
Pine Bluff, AR	18.0874	17.5370
Pittsburgh, PA	21.6212	21.3813
Pittsfield, MA	23.4852	22.9215
Pocatello, ID	19.6333	20.1279
Ponce, PR	12.0062	11.5028
Portland, ME	22.8379	21.6951
Portland-Vancouver, OR-WA	24.7759	24.4428
Providence-Warwick, RI	24.2778	24.0071
Provo-Orem, UT	23.4308	22.3948
Pueblo, CO	20.3670	19.5929
Punta Gorda, FL	17.3909	18.1956
Racine, WI	21.6444	20.8817
Raleigh-Durham-Chapel Hill, NC	23.1852	22.0116
Rapid City, SD	20.5485	19.8947
Reading, PA	21.4029	20.8900
Redding, CA	25.8663	25.3801
Reno, NV	24.5213	23.5887
Richland-Kennewick-Pasco, WA	26.6936	25.3323
Richmond-Petersburg, VA	22.3862	21.6142
Riverside-San Bernardino, CA	25.8718	24.9920
Roanoke, VA	20.0117	19.2433
Rochester, MN	28.1983	26.1811
Rochester, NY	21.0003	20.5991
Rockford, IL	21.7440	20.5098
Rocky Mount, NC	21.4359	20.3593
Sacramento, CA	26.7257	26.3878
Saginaw-Bay City-Midland, MI	22.3260	21.5138
St. Cloud, MN	22.4364	22.0902
[1] St. Joseph, MO	.....	19.7467
St. Louis, MO-IL	20.4806	20.0376
Salem, OR	24.0818	22.8500
Salinas, CA	33.9674	32.7871
Salt Lake City-Ogden, UT	23.0757	22.1425
San Angelo, TX	18.2955	18.0306
San Antonio, TX	19.8888	19.2241
San Diego, CA	25.8535	25.5476
San Francisco, CA	32.8557	31.7475
San Jose, CA	32.5657	31.2857
San Juan-Bayamon, PR	10.8224	10.5408
San Luis Obispo-Atascadero-Paso Robles, CA	26.1821	24.6268
Santa Barbara-Santa Maria-Lompoc, CA	24.3466	23.8325
Santa Cruz-Watsonville, CA	31.3417	31.0243
Santa Fe, NM	24.8842	23.5075
Santa Rosa, CA	30.3046	28.9555
Sarasota-Bradenton, FL	21.4760	21.7771
Savannah, GA	22.9060	22.0969
Scranton-Wilkes Barre-Hazleton, PA	19.5725	19.0594
Seattle-Bellevue-Everett, WA	26.6067	25.2916
Sharon, PA	18.2710	17.7451
Sheboygan, WI	20.1510	19.0711
Sherman-Denison, TX	21.4636	20.3959
Shreveport-Bossier City, LA	20.2644	19.8410
Sioux City, IA-NE	21.0135	19.6404
Sioux Falls, SD	20.9214	20.1349
South Bend, IN	22.7694	22.2819
Spokane, WA	25.2044	23.9682
Springfield, IL	19.9008	19.3840
Springfield, MO	19.5680	19.0448
Springfield, MA	25.4001	24.2504
State College, PA	20.7690	20.2726
Steubenville-Weirton, OH-WV	20.4503	19.4333
Stockton-Lodi, CA	24.0178	23.7561
Sumter, SC	18.8535	18.0764
Syracuse, NY	21.8886	21.3766
Tacoma, WA	25.4131	25.5054
Tallahassee, FL	19.6007	19.0869
Tampa-St. Petersburg-Clearwater, FL	20.9878	20.1427
Terre Haute, IN	19.9743	19.0303
Texarkana, AR-Texarkana, TX	18.7416	18.5107
Toledo, OH	22.6790	21.9714
Topeka, KS	20.5859	20.0981
Trenton, NJ	24.6268	23.3224
Tucson, AZ	20.6783	19.9418
Tulsa, OK	19.3121	19.1851
Tuscaloosa, AL	18.9045	18.2544
Tyler, TX	22.1901	21.3538
Utica-Rome, NY	19.6508	18.9705
Vallejo-Fairfield-Napa, CA	30.9785	29.7068
Ventura, CA	25.7748	24.7503
Victoria, TX	20.2675	18.8655
Vineland-Millville-Bridgeton, NJ	23.6746	23.2888
Visalia-Tulare-Portersville, CA	21.6029	21.2747
Waco, TX	20.2402	18.4397
Washington, DC-MD-VA-WV	24.9537	24.2243
Waterloo-Cedar Falls, IA	18.7281	18.3305
Wausau, WI	22.7239	21.6241
West Palm Beach-Boca Raton, FL	22.8320	21.9092
Wheeling, OH-WV	17.8084	17.4900
Wichita, KS	22.0087	21.3928
Wichita Falls, TX	18.4488	17.5804
Williamsport, PA	19.8310	18.8540
Wilmington-Newark, DE-MD	25.9552	24.8359
Wilmington, NC	21.7789	21.1031
Yakima, WA	24.5502	23.1867
Yolo, CA	21.9147	21.8929

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2002]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
York, PA	21.0167	20.7492
Youngstown-Warren, OH	21.8109	21.2943
Yuba City, CA	23.7087	23.3825
Yuma, AZ	19.9517	20.2223

[1] The MSA is empty for FY 2003. 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 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003]

Nonurban area	FY 2003 average hourly wage	3-Year average hourly wage
Alabama	17.9036	16.8484
Alaska	28.3370	27.2338
Arizona	19.5067	19.0116
Arkansas	17.6380	16.8439
California	22.8280	21.9650
Colorado	20.9354	20.0304
Connecticut	28.7896	27.0512
Delaware	20.9850	20.7345
Florida	20.4812	19.8506
Georgia	18.9804	18.5484
Hawaii	23.7802	24.2085
Idaho	20.2336	19.5324
Illinois	19.0881	18.2692
Indiana	20.2273	19.4705
Iowa	19.3039	18.3140
Kansas	18.3139	17.4523
Kentucky	18.5767	17.8667
Louisiana	17.5606	17.0801
Maine	20.1286	19.5633
Maryland	20.3626	19.6588
Massachusetts	25.8847	25.2714
Michigan	20.5663	20.0744
Minnesota	21.2683	20.2498
Mississippi	17.8117	16.9666
Missouri	18.6096	17.6847
Montana	19.7008	19.3096
Nebraska	19.0466	18.2894
Nevada	21.8882	21.2045
New Hampshire	22.7236	21.9972
New Jersey [1]	.....	.....
New Mexico	19.8780	19.2303
New York	19.8523	19.1400
North Carolina	20.0381	19.1521
North Dakota	18.0060	17.4398
Ohio	19.9481	19.3896
Oklahoma	17.6227	16.9222
Oregon	23.9321	22.8031
Pennsylvania	19.6030	19.1490
Puerto Rico	10.1187	10.0248

TABLE 3B.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003]

Nonurban area	FY 2003 average hourly wage	3-Year average hourly wage
Rhode Island [1]	.....	.....
South Carolina	19.7928	19.0083
South Dakota	18.1545	17.3648
Tennessee	18.1050	17.6144
Texas	17.8263	17.1186
Utah	21.6749	20.5059
Vermont	21.6208	20.9793
Virginia	19.5315	18.5749
Washington	23.6253	23.0484
West Virginia	18.5169	18.1434
Wisconsin	21.2222	20.2660
Wyoming	20.4416	19.7159

[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	0.9268	0.9493
0060 Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4634	0.5905
0080 Akron, OH Portage, OH Summit, OH	0.9685	0.9783
0120 Albany, GA Dougherty, GA Lee, GA	1.0835	1.0565
0160 [2] Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8633	0.9042
0200 Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.9372	0.9566
0220 Alexandria, LA Rapides, LA	0.7929	0.8531
0240 Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9833	0.9885
0280 Altoona, PA Blair, PA	0.9300	0.9515
0320 Amarillo, TX Potter, TX Randall, TX	0.9051	0.9340
0380 Anchorage, AK Anchorage, AK	1.2610	1.1721
0440 Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.1217	1.0818

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
0450 Anniston, AL Calhoun, AL	0.8126	0.8675
0460 [2] Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.9229	0.9465
0470 [2] Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.4400	0.5699
0480 Asheville, NC Buncombe, NC Madison, NC	0.9682	0.9781
0500 Athens, GA Clarke, GA Madison, GA Oconee, GA	1.0308	1.0210
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 Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA	1.0091	1.0062
0560 Atlantic-Cape May, NJ Atlantic, NJ Cape May, NJ	1.1058	1.0713
0580 Auburn-Opelika, AL Lee, AL	0.8306	0.8806
0600 Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	1.0364	1.0248
0640 [1] Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9529	0.9675
0680 Bakersfield, CA Kern, CA	1.0186	1.0127
0720 [1] Baltimore, MD Anne Arundel, MD Baltimore, MD	0.9757	0.9833

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9791	0.9856
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3127	1.2048
Barnstable, MA		
0760 Baton Rouge, LA	0.8388	0.8866
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8389	0.8867
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.2407	1.1592
Whatcom, WA		
0870 Benton Harbor, MI	0.9072	0.9355
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.2100	1.1394
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9114	0.9384
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8830	0.9183
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 [2] Binghamton, NY	0.8633	0.9042
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9301	0.9516
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7881	0.8495
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8997	0.9302
Monroe, IN		
1040 Bloomington-Normal, IL	0.9202	0.9446
McLean, IL		
1080 Boise City, ID	0.9403	0.9587
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1304	1.0876
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	0.9688	0.9785
Boulder, CO		
1145 Brazoria, TX	0.8617	0.9031
Brazoria, TX		
1150 Bremerton, WA	1.1056	1.0712
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8992	0.9298
Cameron, TX		
1260 Bryan-College Station, TX	0.8410	0.8882
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9464	0.9630
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0176	1.0120
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4453	0.5746
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.9026	0.9322
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9788	0.9854
Natrona, WY		
1360 Cedar Rapids, IA	0.9149	0.9409
Linn, IA		
1400 Champaign-Urbana, IL	0.9983	0.9988
Champaign, IL		
1440 [2] Charleston-North Charleston, SC	0.8607	0.9024
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.8765	0.9137
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9839	0.9889
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0583	1.0396
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.9069	0.9353
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8890	0.9226
Laramie, WY		
1600 [1] Chicago, IL	1.1088	1.0733
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 [2] Chico-Paradise, CA	0.9934	0.9955
Butte, CA		
1640 [1] Cincinnati, OH-KY-IN	0.9354	0.9553
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	0.8386	0.8864
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9295	0.9512
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9968	0.9978
El Paso, CO		
1740 Columbia, MO	0.8737	0.9117
Boone, MO		
1760 Columbia, SC	0.8990	0.9297
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.8450	0.8911
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9705	0.9797
Delaware, OH		
Fairfield, OH		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8154	0.8696
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1569	1.1050
Benton, OR		
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.8855	0.9201
Allegany, MD		
Mineral, WV		
1900 [2] Cumberland, MD-WV (WV Hospitals)	0.8053	0.8622
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9831	0.9884
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8785	0.9151
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA-IL	0.8872	0.9213
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9378	0.9570
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9133	0.9398
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.9066	0.9351
Lawrence, AL		
Morgan, AL		
2040 [2] Decatur, IL	0.8301	0.8803
Macon, IL		
2080 [1] Denver, CO	1.0401	1.0273
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8908	0.9239
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0506	1.0344
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.8028	0.8603
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9452	0.9621
Kent, DE		
2200 Dubuque, IA	0.8801	0.9163
Dubuque, IA		
2240 Duluth-Superior, MN-WI	1.0462	1.0314
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0793	1.0536
Dutchess, NY		
2290 [2] Eau Claire, WI	0.9229	0.9465
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9137	0.9401
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9851	0.9898
Elkhart, IN		
2335 [2] Elmira, NY	0.8633	0.9042
Chemung, NY		
2340 Enid, OK	0.8387	0.8865
Garfield, OK		
2360 Erie, PA	0.9016	0.9315
Erie, PA		
2400 Eugene-Springfield, OR	1.1077	1.0726
Lane, OR		
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8796	0.9159
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8254	0.8769
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.9783	0.9851
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.9055	0.9343
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.8182	0.8716
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ-UT	1.0791	1.0535
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1233	1.0829
Genesee, MI		
2650 Florence, AL	0.7960	0.8554
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8869	0.9211
Florence, SC		
2670 Fort Collins-Loveland, CO	0.9923	0.9947
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0792	1.0536
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9456	0.9624
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	0.9959	0.9972
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR-OK	0.7811	0.8444
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.9651	0.9760
Okaloosa, FL		
2760 Fort Wayne, IN	0.9499	0.9654
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9620	0.9738
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0340	1.0232
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8684	0.9079
Etowah, AL		
2900 Gainesville, FL	0.9730	0.9814
Alachua, FL		
2920 Galveston-Texas City, TX	0.9603	0.9726
Galveston, TX		
2960 Gary, IN	0.9676	0.9777
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8633	0.9042
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8982	0.9291
Wayne, NC		
2985 Grand Forks, ND-MN	0.9338	0.9542
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9824	0.9879
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9664	0.9769
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
3040 Great Falls, MT	0.9057	0.9344
Cascade, MT		
3060 Greeley, CO	0.9219	0.9458
Weld, CO		
3080 Green Bay, WI	0.9599	0.9724
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9270	0.9494
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9257	0.9485
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9177	0.9429
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9362	0.9559
Washington, MD		
3200 Hamilton-Middletown, OH	0.9484	0.9644
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9315	0.9526
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1 2] Hartford, CT	1.2520	1.1664
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7759	0.8405
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.8958	0.9274
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1121	1.0755
Honolulu, HI		
3350 Houma, LA	0.8470	0.8925
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9746	0.9825
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.9744	0.9824
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8901	0.9234
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9828	0.9882
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	1.0025	1.0017
Johnson, IA		
3520 Jackson, MI	0.9591	0.9718
Jackson, MI		
3560 Jackson, MS	0.8713	0.9100
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.9370	0.9564
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9341	0.9544
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8714	0.9100
Onslow, NC		
3610 [2] Jamestown, NY	0.8633	0.9042
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9696	0.9791
Rock, WI		
3640 Jersey City, NJ	1.1200	1.0807
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8384	0.8863
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8494	0.8942
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8525	0.8965
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7906	0.8514
Craighead, AR		
3710 Joplin, MO	0.8700	0.9090
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0689	1.0467
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9591	0.9718
Kankakee, IL		
3760 [1] Kansas City, KS-MO	0.9809	0.9869
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	0.9741	0.9822
Kenosha, WI		
3810 Killeen-Temple, TX	0.8447	0.8909
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.9090	0.9368
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9031	0.9326
Howard, IN		
Tipton, IN		
3870 [2] La Crosse, WI-MN (WI Hospitals)	0.9229	0.9465
Houston, MN		
La Crosse, WI		
3870 [2] La Crosse, WI-MN (MN Hospitals)	0.9249	0.9479
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8550	0.8983
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9515	0.9665
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8030	0.8605
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.9170	0.9424
Polk, FL		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
4000 Lancaster, PA ...	0.9171	0.9425
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9827	0.9881
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8504	0.8950
Webb, TX		
4100 Las Cruces, NM	0.8888	0.9224
Dona Ana, NM		
4120 [1] Las Vegas, NV-AZ	1.1018	1.0686
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.7964	0.8556
Douglas, KS		
4200 Lawton, OK	0.8251	0.8766
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9249	0.9479
Androscoggin, ME		
4280 Lexington, KY	0.8629	0.9040
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9515	0.9665
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9133	0.9398
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.9045	0.9336
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8588	0.9010
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.2044	1.1358
Los Angeles, CA		
4520 [1] Louisville, KY-IN	0.9517	0.9667
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.7809	0.8442
Lubbock, TX		
4640 Lynchburg, VA ..	0.9311	0.9523
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9296	0.9512
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0188	1.0128
Dane, WI		
4800 Mansfield, OH ...	0.8989	0.9296
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR ..	0.4921	0.6153
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8419	0.8888
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0605	1.0410
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	1.0782	1.0529
Brevard, Fl		
4920 [1] Memphis, TN-AR-MS	0.8839	0.9190
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	0.9937	0.9957
Merced, CA		
5000 [1] Miami, FL	0.9878	0.9916
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1454	1.0974
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9901	0.9932
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN-WI	1.0969	1.0654
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	0.9250	0.9480
Missoula, MT		
5160 Mobile, AL	0.8181	0.8715
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0606	1.0411
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1290	1.0866
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8191	0.8723
Ouachita, LA		
5240 [2] Montgomery, AL	0.7853	0.8475
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9150	0.9410
Delaware, IN		
5330 Myrtle Beach, SC	0.9141	0.9403
Horry, SC		
5345 Naples, FL	0.9803	0.9865
Collier, FL		
5360 [1] Nashville, TN ..	0.9456	0.9624
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3441	1.2245
Nassau, NY		
Suffolk, NY		
5483 [1 2] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2520	1.1664
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2520	1.1664
New London, CT		
5560 [1] New Orleans, LA	0.9050	0.9339
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	1.4069	1.2634
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
5640 [1] Newark, NJ	1.1546	1.1035
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1434	1.0961
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8553	0.8985
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	1.5324	1.3395
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9526	0.9673
Marion, FL		
5800 Odessa-Midland, TX	0.9233	0.9468
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8997	0.9302
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1071	1.0722
Thurston, WA		
5920 Omaha, NE-IA	1.0089	1.0061
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1726	1.1152
Orange, CA		
5960 [1] Orlando, FL	0.9537	0.9681
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8283	0.8790
Daviess, KY		
6015 Panama City, FL	0.8926	0.9251
Bay, FL		
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8210	0.8737
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8675	0.9072
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8907	0.9238
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8854	0.9200
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA-NJ	1.0675	1.0457
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9562	0.9698
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7866	0.8484
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9403	0.9587
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1257	1.0845
Berkshire, MA		
6340 Pocatello, ID	0.9013	0.9313
Bannock, ID		
6360 Ponce, PR	0.5221	0.6408
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9932	0.9953
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR-WA	1.0792	1.0536
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0558	1.0379
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0190	1.0130
Utah, UT		
6560 [2] Pueblo, CO	0.9104	0.9377
Pueblo, CO		
6580 [2] Punta Gorda, FL	0.8907	0.9238
Charlotte, FL		
6600 Racine, WI	0.9413	0.9594
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	1.0083	1.0057
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8936	0.9259
Pennington, SD		
6680 Reading, PA	0.9308	0.9521
Berks, PA		
6690 Redding, CA	1.1249	1.0839
Shasta, CA		
6720 Reno, NV	1.0664	1.0450
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1608	1.1075
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9735	0.9818
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	1.1251	1.0841
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8703	0.9093
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.2263	1.1499
Olmsted, MN		
6840 [1] Rochester, NY	0.9133	0.9398
Genesee, NY		
Livingston, NY		
Monroe, NY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9456	0.9624
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9322	0.9531
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1636	1.1093
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9709	0.9800
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9858	0.9903
Benton, MN		
Stearns, MN		
7000 [2] St. Joseph, MO	0.8099	0.8656
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.8907	0.9238
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	1.0473	1.0322
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4772	1.3063
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	1.0035	1.0024
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7956	0.8551
Tom Green, TX		
7240 [1] San Antonio, TX	0.8649	0.9054
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1247	1.0838
San Diego, CA		
7360 [1] San Francisco, CA	1.4288	1.2768
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4162	1.2691
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4706	0.5968
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	1.1386	1.0930
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0588	1.0399
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3630	1.2362
Santa Cruz, CA		
7490 Santa Fe, NM	1.0822	1.0556
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3179	1.2081
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9367	0.9562
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9961	0.9973
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 [2] Scranton--Wilkes-Barre--Hazleton, PA	0.8525	0.8965
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1571	1.1051
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8525	0.8965
Mercer, PA		
7620 [2] Sheboygan, WI	0.9229	0.9465
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9334	0.9539
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.8813	0.9171
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.9138	0.9401
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.9098	0.9373
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9902	0.9933
St. Joseph, IN		
7840 Spokane, WA	1.0961	1.0649
Spokane, WA		
7880 Springfield, IL	0.8654	0.9057
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8510	0.8954
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2] Springfield, MA	1.1257	1.0845
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9032	0.9327
Centre, PA		
8080 Steubenville-Weirton, OH-WV	0.8893	0.9228
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0630	1.0427
San Joaquin, CA		
8140 [2] Sumter, SC	0.8607	0.9024
Sumter, SC		
8160 Syracuse, NY	0.9519	0.9668
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1052	1.0709
Pierce, WA		
8240 [2] Tallahassee, FL	0.8907	0.9238
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9238	0.9472
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2] Terre Haute, IN	0.8796	0.9159

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana,AR-Texarkana, TX	0.8193	0.8724
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9863	0.9906
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.8952	0.9270
Shawnee, KS		
8480 Trenton, NJ	1.0710	1.0481
Mercer, NJ		
8520 Tucson, AZ	0.8993	0.9299
Pima, AZ		
8560 Tulsa, OK	0.8398	0.8873
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8303	0.8804
Tuscaloosa, AL		
8640 Tyler, TX	0.9650	0.9759
Smith, TX		
8680 [2] Utica-Rome, NY	0.8633	0.9042
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3544	1.2309
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.1209	1.0813
Ventura, CA		
8750 Victoria, TX	0.8814	0.9172
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0296	1.0202
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9934	0.9955
Tulare, CA		
8800 Waco, TX	0.8802	0.9163
McLennan, TX		
8840 [1] Washington, DC-MD-VA-WV	1.0852	1.0576
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	0.8970	0.9283
Black Hawk, IA		
8940 Wausau, WI	0.9882	0.9919
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	0.9929	0.9951
Palm Beach, FL		
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8053	0.8622
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8675	0.9072
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9571	0.9704
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.8023	0.8600
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8624	0.9036
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.1287	1.0864
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9471	0.9635
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	1.0676	1.0458
Yakima, WA		
9270 [2] Yolo, CA	0.9934	0.9955
Yolo, CA		
9280 York, PA	0.9140	0.9403
York, PA		
9320 Youngstown-Warren, OH	0.9485	0.9644
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0310	1.0211
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.8677	0.9074
Yuma, AZ		

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2003.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7853	0.8475
Alaska	1.2323	1.1538
Arizona	0.8483	0.8935
Arkansas	0.7670	0.8339
California	0.9934	0.9988
Colorado	0.9104	0.9377
Connecticut	1.2520	1.1664
Delaware	0.9126	0.9393
Florida	0.8907	0.9238
Georgia	0.8254	0.8769
Hawaii	1.0342	1.0233
Idaho	0.8799	0.9161
Illinois	0.8301	0.8803
Indiana	0.8796	0.9159
Iowa	0.8395	0.8871
Kansas	0.7964	0.8556
Kentucky	0.8079	0.8641
Louisiana	0.7719	0.8375
Maine	0.8754	0.9129
Maryland	0.8855	0.9201
Massachusetts	1.1257	1.0845
Michigan	0.8961	0.9276
Minnesota	0.9249	0.9479
Mississippi	0.7759	0.8405
Missouri	0.8099	0.8656
Montana	0.8567	0.8995
Nebraska	0.8283	0.8790
Nevada	0.9519	0.9668
New Hampshire	0.9882	0.9919
New Jersey [1]	.....	.....
New Mexico	0.8645	0.9051
New York	0.8633	0.9042
North Carolina	0.8714	0.9100
North Dakota	0.7830	0.8458
Ohio	0.8675	0.9072
Oklahoma	0.7664	0.8334
Oregon	1.0408	1.0278
Pennsylvania	0.8525	0.8965
Puerto Rico	0.4400	0.5699
Rhode Island [1]	.....	.....
South Carolina	0.8607	0.9024
South Dakota	0.7895	0.8506
Tennessee	0.7873	0.8489
Texas	0.7759	0.8405
Utah	0.9426	0.9603
Vermont	0.9402	0.9587
Virginia	0.8494	0.8942
Washington	1.0274	1.0187
West Virginia	0.8053	0.8622
Wisconsin	0.9229	0.9465
Wyoming	0.8890	0.9226

[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	0.8534	0.8971
Akron, OH	0.9685	0.9783
Albany, GA	1.0658	1.0446
Albuquerque, NM	0.9372	0.9566
Alexandria, LA	0.7929	0.8531

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Allentown-Bethlehem-Easton, PA	0.9833	0.9885
Altoona, PA	0.9300	0.9515
Amarillo, TX	0.8900	0.9233
Anchorage, AK	1.2610	1.1721
Ann Arbor, MI	1.1217	1.0818
Anniston, AL	0.7983	0.8570
Asheville, NC	0.9448	0.9619
Athens, GA	1.0161	1.0110
Atlanta, GA	0.9985	0.9990
Augusta-Aiken, GA-SC	0.9981	0.9987
Austin-San Marcos, TX	0.9529	0.9675
Barnstable-Yarmouth, MA	1.2894	1.1901
Baton Rouge, LA	0.8281	0.8788
Bellingham, WA	1.2139	1.1420
Benton Harbor, MI	0.9072	0.9355
Bergen-Passaic, NJ	1.2100	1.1394
Billings, MT	0.9114	0.9384
Biloxi-Gulfport-Pascagoula, MS	0.8417	0.8887
Binghamton, NY	0.8525	0.8965
Birmingham, AL	0.9301	0.9516
Bismarck, ND	0.7881	0.8495
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1304	1.0876
Burlington, VT	0.9667	0.9771
Caguas, PR	0.4453	0.5746
Casper, WY	0.9655	0.9762
Champaign-Urbana, IL	0.9334	0.9539
Charleston-North Charleston, SC	0.8607	0.9024
Charleston, WV	0.8602	0.9020
Charlotte-Gastonia-Rock Hill, NC-SC	0.9839	0.9889
Charlottesville, VA	1.0252	1.0172
Chattanooga, TN-GA	0.8878	0.9217
Chicago, IL	1.0953	1.0643
Cincinnati, OH-KY-IN	0.9354	0.9553
Clarksville-Hopkinsville, TN-KY	0.8239	0.8758
Cleveland-Lorain-Elyria, OH	0.9295	0.9512
Columbia, MO	0.8737	0.9117
Columbia, SC	0.8990	0.9297
Columbus, GA-AL (GA Hospitals)	0.8254	0.8769
Columbus, GA-AL (AL Hospitals)	0.8041	0.8613
Columbus, OH	0.9521	0.9669
Corpus Christi, TX	0.8154	0.8696
Dallas, TX	0.9831	0.9884
Danville, VA	0.8530	0.8968
Davenport-Moline-Rock Island, IA-IL	0.8872	0.9213
Dayton-Springfield, OH	0.9378	0.9570
Denver, CO	1.0401	1.0273
Des Moines, IA	0.8908	0.9239
Detroit, MI	1.0506	1.0344
Dothan, AL	0.8028	0.8603
Dover, DE	0.9274	0.9497
Duluth-Superior, MN-WI	1.0462	1.0314
Eau Claire, WI	0.9229	0.9465
Elkhart-Goshen, IN	0.9484	0.9643
Erie, PA	0.8850	0.9197
Eugene-Springfield, OR	1.1077	1.0726
Fargo-Moorhead, ND-MN	0.9564	0.9699
Fayetteville, NC	0.9055	0.9343
Flagstaff, AZ-UT	1.0234	1.0160
Flint, MI	1.1041	1.0702
Florence, AL	0.7960	0.8554
Florence, SC	0.8869	0.9211
Fort Collins-Loveland, CO	0.9923	0.9947
Ft. Lauderdale, FL	1.0792	1.0536
Fort Pierce-Port St. Lucie, FL	0.9959	0.9972
Fort Smith, AR-OK	0.7681	0.8347
Fort Walton Beach, FL	0.9365	0.9561
Forth Worth-Arlington, TX	0.9620	0.9738
Gadsden, AL	0.8684	0.9079
Grand Forks, ND-MN	0.9338	0.9542
Grand Junction, CO	0.9824	0.9879
Grand Rapids-Muskegon-Holland, MI	0.9664	0.9769
Great Falls, MT	0.9057	0.9344
Greeley, CO	0.9219	0.9458
Green Bay, WI	0.9347	0.9548
Greensboro-Winston-Salem-High Point, NC	0.9131	0.9396
Greenville, NC	0.9257	0.9485
Harrisburg-Lebanon-Carlisle, PA	0.9315	0.9526
Hartford, CT	1.1550	1.1037
Hattiesburg, MS	0.7759	0.8405
Hickory-Morganton-Lenoir, NC	0.8958	0.9274
Houston, TX	0.9746	0.9825
Huntington-Ashland, WV-KY-OH	0.9251	0.9481
Huntsville, AL	0.8901	0.9234
Indianapolis, IN	0.9828	0.9882
Iowa City, IA	0.9828	0.9882
Jackson, MS	0.8587	0.9009
Jackson, TN	0.9032	0.9327
Jacksonville, FL	0.9225	0.9463
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8494	0.8942
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8384	0.8863
Jonesboro, AR (AR Hospitals)	0.7906	0.8514
Jonesboro, AR (MO Hospitals)	0.8099	0.8656
Joplin, MO	0.8700	0.9090
Kalamazoo-Battlecreek, MI	1.0490	1.0333
Kansas City, KS-MO	0.9809	0.9869
Knoxville, TN	0.9090	0.9368
Kokomo, IN	0.9031	0.9326
Lafayette, LA	0.8392	0.8869
Lakeland-Winter Haven, FL	0.9170	0.9424
Las Vegas, NV-AZ	1.1018	1.0686
Lawton, OK	0.8073	0.8636
Lexington, KY	0.8629	0.9040
Lima, OH	0.9515	0.9665
Lincoln, NE	0.9133	0.9398
Little Rock-North Little Rock, AR	0.8926	0.9251
Longview-Marshall, TX	0.8588	0.9010
Los Angeles-Long Beach, CA	1.2044	1.1358
Louisville, KY-IN	0.9382	0.9573
Lubbock, TX	0.7809	0.8442
Lynchburg, VA	0.9114	0.9384
Macon, GA	0.9296	0.9512
Madison, WI	1.0188	1.0128
Mansfield, OH	0.8989	0.9296
Medford-Ashland, OR	1.0408	1.0278
Memphis, TN-AR-MS	0.8667	0.9067
Miami, FL	0.9878	0.9916
Milwaukee-Waukesha, WI	0.9901	0.9932
Minneapolis-St. Paul, MN-WI	1.0969	1.0654
Missoula, MT	0.9139	0.9402
Mobile, AL	0.8181	0.8715
Modesto, CA	1.0606	1.0411
Monmouth-Ocean, NJ	1.1290	1.0866
Monroe, LA	0.8191	0.8723
Montgomery, AL	0.7853	0.8475
Nashville, TN	0.9283	0.9503
New Haven-Bridgeport-Stamford-Waterbury-. Danbury, CT	1.2520	1.1664
New London-Norwich, CT	1.1683	1.1124
New Orleans, LA	0.9050	0.9339
New York, NY	1.3936	1.2552
Newark, NJ	1.1546	1.1035
Newburgh, NY-PA	1.0820	1.0555
Norfolk-Virginia Beach-Newport News, VA-NC	0.8714	0.9100
Oakland, CA	1.5324	1.3395
Ocala, FL	0.9343	0.9545
Odessa-Midland, TX	0.8910	0.9240
Oklahoma City, OK	0.8997	0.9302
Omaha, NE-IA	1.0089	1.0061
Orange County, CA	1.1726	1.1152
Orlando, FL	0.9537	0.9681
Peoria-Pekin, IL	0.8854	0.9200
Philadelphia, PA-NJ	1.0675	1.0457
Phoenix-Mesa, AZ	0.9562	0.9698
Pine Bluff, AR	0.7760	0.8406
Pittsburgh, PA	0.9268	0.9493
Pittsfield, MA	0.9869	0.9910
Pocatello, ID	0.9013	0.9313
Portland, ME	0.9698	0.9792
Portland-Vancouver, OR-WA	1.0792	1.0536
Provo-Orem, UT	1.0088	1.0060
Raleigh-Durham-Chapel Hill, NC	0.9978	0.9985
Rapid City, SD	0.8936	0.9259
Reading, PA	0.9126	0.9393
Redding, CA	1.1249	1.0839
Reno, NV	1.0445	1.0303
Richland-Kennewick-Pasco, WA	1.1209	1.0813
Richmond-Petersburg, VA	0.9735	0.9818

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Roanoke, VA	0.8703	0.9093
Rochester, MN	1.2263	1.1499
Rockford, IL	0.9456	0.9624
Sacramento, CA	1.1636	1.1093
Saginaw-Bay City-Midland, MI	0.9709	0.9800
St. Cloud, MN	0.9858	0.9903
St. Joseph, MO	0.8300	0.8802
St. Louis, MO-IL	0.8907	0.9238
Salinas, CA	1.4772	1.3063
Salt Lake City-Ogden, UT	1.0035	1.0024
San Antonio, TX	0.8649	0.9054
San Diego, CA	1.1247	1.0838
Santa Fe, NM	0.9927	0.9950
Santa Rosa, CA	1.2891	1.1899
Sarasota-Bradenton, FL	0.9367	0.9562
Savannah, GA	0.9841	0.9891
Seattle-Bellevue-Everett, WA	1.1571	1.1051
Sherman-Denison, TX	0.9090	0.9368
Shreveport-Bossier City, LA	0.8813	0.9171
Sioux City, IA-NE	0.8736	0.9116
Sioux Falls, SD	0.8950	0.9268
South Bend, IN	0.9902	0.9933
Spokane, WA	1.0770	1.0521
Springfield, IL	0.8654	0.9057
Springfield, MO	0.8236	0.8756
Stockton-Lodi, CA	1.0630	1.0427
Syracuse, NY	0.9519	0.9668
Tampa-St. Petersburg-Clearwater, FL	0.9238	0.9472
Texarkana,AR-Texarkana, TX	0.8193	0.8724
Toledo, OH	0.9863	0.9906
Topeka, KS	0.8840	0.9190
Tucson, AZ	0.8993	0.9299
Tulsa, OK	0.8398	0.8873
Tuscaloosa, AL	0.8303	0.8804
Tyler, TX	0.9249	0.9479
Vallejo-Fairfield-Napa, CA	1.3544	1.2309
Victoria, TX	0.8668	0.9067
Waco, TX	0.8671	0.9070
Washington, DC-MD-VA-WV	1.0852	1.0576
Waterloo-Cedar Falls, IA	0.8970	0.9283
Wausau, WI	0.9710	0.9800
West Palm Beach-Boca Raton, FL	0.9929	0.9951
Wichita, KS	0.9235	0.9470
Wichita Falls, TX	0.7918	0.8523
Wilmington-Newark, DE-MD	1.0973	1.0657
Wilmington, NC	0.9336	0.9540
York, PA	0.9140	0.9403
Youngstown-Warren, OH	0.9485	0.9644
Rural Alabama	0.7853	0.8475
Rural Florida	0.8907	0.9238
Rural Illinois (IA Hospitals)	0.8395	0.8871
Rural Illinois (MO Hospitals)	0.8301	0.8803
Rural Kentucky	0.8079	0.8641
Rural Louisiana	0.7719	0.8375
Rural Massachusetts	1.0417	1.0284
Rural Michigan	0.8961	0.9276
Rural Minnesota	0.9249	0.9479
Rural Mississippi	0.7759	0.8405
Rural Missouri	0.8099	0.8656
Rural Montana	0.8567	0.8995
Rural Nebraska	0.8283	0.8790
Rural Nevada	0.9097	0.9372
Rural Texas	0.7759	0.8405
Rural Washington	1.0274	1.0187
Rural Wyoming	0.8890	0.9226

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—reclass. hospitals
Aguadilla, PR	0.9781	0.9850	.....	.....
[1] Arecibo, PR	0.9289	0.9507	.....	.....
Caguas, PR	0.9400	0.9585	0.9400	0.9585
Mayaguez, PR	1.0388	1.0264	.....	.....
Ponce, PR	1.1021	1.0688	.....	.....
San Juan-Bayamon, PR	0.9935	0.9955	.....	.....
Rural Puerto Rico	0.9289	0.9507	.....	.....

[1] Hospitals geographically located in the area are assigned the Rural Puerto Rico wage index for FY 2003.

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.9268
Taylor, TX	
0060 Aguadilla, PR	0.4634
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9685
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0835
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8633
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9279
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7903
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9833
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9300
Blair, PA	
0320 Amarillo, TX	0.9051
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2477
Anchorage, AK	
0440 Ann Arbor, MI	1.1217
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8126
Calhoun, AL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
0460 Appleton-Oshkosh-Neenah, WI	0.9229
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4400
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9682
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0308
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0091
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	1.1058
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8306
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0364
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9529
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	1.0186
Kern, CA	
0720 Baltimore, MD	0.9757
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9791
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3127
Barnstable, MA	
0760 Baton Rouge, LA	0.8388
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8389
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2407
Whatcom, WA	
0870 Benton Harbor, MI	0.8992
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2100
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9114
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8830
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8633
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9301
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7848
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8997
Monroe, IN	
1040 Bloomington-Normal, IL	0.9202
McLean, IL	
1080 Boise City, ID	0.9403
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1304
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	0.9688
Boulder, CO	
1145 Brazoria, TX	0.8617
Brazoria, TX	
1150 Bremerton, WA	1.1056
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8992
Cameron, TX	
1260 Bryan-College Station, TX	0.8410
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9464
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0176
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4415
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9026
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9788
Natrona, WY	
1360 Cedar Rapids, IA	0.9149
Linn, IA	
1400 Champaign-Urbana, IL	0.9983
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8607
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8765
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9839
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0583
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9069
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.8890
Laramie, WY	
1600 Chicago, IL	1.1088
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9934
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9323
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8386
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9295
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9968
El Paso, CO	
1740 Columbia, MO	0.8737
Boone, MO	
1760 Columbia, SC	0.8990
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8450
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9705
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8154
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1569
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.8053
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9831
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8785
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8872
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9378
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9133
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.9066
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8301
Macon, IL	
2080 Denver, CO	1.0401
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8867
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0506
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7990
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9452
Kent, DE	
2200 Dubuque, IA	0.8801
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0462
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0793
Dutchess, NY	
2290 Eau Claire, WI	0.9229
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9137
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9851
Elkhart, IN	
2335 Elmira, NY	0.8633
Chemung, NY	
2340 Enid, OK	0.8387
Garfield, OK	
2360 Erie, PA	0.9016
Erie, PA	
2400 Eugene-Springfield, OR	1.1077
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8796
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9783
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8980
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8182
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0791
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1233
Genesee, MI	
2650 Florence, AL	0.7927
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8869
Florence, SC	
2670 Fort Collins-Loveland, CO	0.9923
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0368
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9456
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9802
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7811
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9651
Okaloosa, FL	
2760 Fort Wayne, IN	0.9499
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9620
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0340
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8580
Etowah, AL	
2900 Gainesville, FL	0.9730
Alachua, FL	
2920 Galveston-Texas City, TX	0.9603
Galveston, TX	
2960 Gary, IN	0.9676
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8633
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8982
Wayne, NC	
2985 Grand Forks, ND-MN	0.8988
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9615
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	0.9645
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9042
Cascade, MT	
3060 Greeley, CO	0.9104
Weld, CO	
3080 Green Bay, WI	0.9599
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9270
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9177
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9177
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9362
Washington, MD	
3200 Hamilton-Middletown, OH	0.9484
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9315
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2520
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7746
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.8958
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1121
Honolulu, HI	
3350 Houma, LA	0.8470
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9746
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9744
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8901
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9828
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	1.0025
Johnson, IA	
3520 Jackson, MI	0.9591
Jackson, MI	
3560 Jackson, MS	0.8713
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9370
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9341
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8714
Onslow, NC	
3610 Jamestown, NY	0.8633
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9696
Rock, WI	
3640 Jersey City, NJ	1.1200
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8307
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8525
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7828
Craighead, AR	
3710 Joplin, MO	0.8700
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0689
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9591
Kankakee, IL	
3760 Kansas City, KS-MO	0.9809
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	0.9741
Kenosha, WI	
3810 Killeen-Temple, TX	0.8447
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.9090
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8950
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9229
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8550
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9515
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.8030
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9162
Polk, FL	
4000 Lancaster, PA	0.9171
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9827
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8504
Webb, TX	
4100 Las Cruces, NM	0.8888
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1018
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7964
Douglas, KS	
4200 Lawton, OK	0.8251
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9249
Androscoggin, ME	
4280 Lexington, KY	0.8629
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9515
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.8928
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.9045
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8588
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2027
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9517
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.7752
Lubbock, TX	
4640 Lynchburg, VA	0.9311
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9259
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0188
Dane, WI	
4800 Mansfield, OH	0.8989
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4921
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8419
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0605
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	1.0782
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8839
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9937
Merced, CA	
5000 Miami, FL	0.9864
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1454
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9901
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.0969
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	0.9250
Missoula, MT	
5160 Mobile, AL	0.8179
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0606
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.1270
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8191
Ouachita, LA	
5240 Montgomery, AL	0.7786
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9150
Delaware, IN	
5330 Myrtle Beach, SC	0.9141
Horry, SC	
5345 Naples, FL	0.9803
Collier, FL	
5360 Nashville, TN	0.9456
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3441
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2520
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2520
New London, CT	
5560 New Orleans, LA	0.9050
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	1.4069
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1504
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1434
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8553
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	1.5222
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9526
Marion, FL	
5800 Odessa-Midland, TX	0.9233
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8997
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1071
Thurston, WA	
5920 Omaha, NE-IA	1.0089
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1604
Orange, CA	
5960 Orlando, FL	0.9537
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8283
Daviess, KY	
6015 Panama City, FL	0.8926
Bay, FL	
6020 Parkersburg-Marietta, WV-OH	0.8210
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8907
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8854
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0675
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9562
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7866
Jefferson, AR	
6280 Pittsburgh, PA	0.9403
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.1257
Berkshire, MA	
6340 Pocatello, ID	0.8799
Bannock, ID	
6360 Ponce, PR	0.5221
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9932
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.0774
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0558
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0190
Utah, UT	
6560 Pueblo, CO	0.9104
Pueblo, CO	
6580 Punta Gorda, FL	0.8907
Charlotte, FL	
6600 Racine, WI	0.9413
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	1.0083
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8936
Pennington, SD	
6680 Reading, PA	0.9308
Berks, PA	
6690 Redding, CA	1.1249
Shasta, CA	
6720 Reno, NV	1.0664
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1608
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9735
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	1.1251
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8703
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.2263
Olmsted, MN	
6840 Rochester, NY	0.9133
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9456
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9322
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1622
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9709
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9757
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.8093
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8907
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	1.0473
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4772
Monterey, CA	
7160 Salt Lake City-Ogden, UT	1.0035
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7956
Tom Green, TX	
7240 San Antonio, TX	0.8649
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1243
San Diego, CA	
7360 San Francisco, CA	1.4288
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4162
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4706
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	1.1386
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0588
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3630
Santa Cruz, CA	
7490 Santa Fe, NM	1.0822
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3179
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9339
Manatee, FL	
Sarasota, FL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
7520 Savannah, GA	0.9961
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8525
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1571
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8525
Mercer, PA	
7620 Sheboygan, WI	0.9229
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9334
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8813
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9138
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9098
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9902
St. Joseph, IN	
7840 Spokane, WA	1.0961
Spokane, WA	
7880 Springfield, IL	0.8654
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8510
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.1257
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9032
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8893
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0445
San Joaquin, CA	
8140 Sumter, SC	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9519
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1052
Pierce, WA	
8240 Tallahassee, FL	0.8907
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9127
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8796
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8150
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9863
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8952
Shawnee, KS	
8480 Trenton, NJ	1.0710
Mercer, NJ	
8520 Tucson, AZ	0.8993
Pima, AZ	
8560 Tulsa, OK	0.8398
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8221
Tuscaloosa, AL	
8640 Tyler, TX	0.9650
Smith, TX	
8680 Utica-Rome, NY	0.8633
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3472
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1209
Ventura, CA	
8750 Victoria, TX	0.8814
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0296
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9934
Tulare, CA	
8800 Waco, TX	0.8802
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0852
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	0.8395
Black Hawk, IA	
8940 Wausau, WI	0.9882
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9929
Palm Beach, FL	
9000 Wheeling, WV-OH	0.8053
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9571
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8023
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8624
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1287
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9471
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0676
Yakima, WA	
9270 Yolo, CA	0.9934
Yolo, CA	
9280 York, PA	0.9140
York, PA	
9320 Youngstown-Warren, OH	0.9485
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0310
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8677
Yuma, AZ	

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7786
Alaska	1.2323
Arizona	0.8483
Arkansas	0.7670
California	0.9934
Colorado	0.9104
Connecticut	1.2520
Delaware	0.9126
Florida	0.8907
Georgia	0.8254
Hawaii	1.0342
Idaho	0.8799
Illinois	0.8301
Indiana	0.8796
Iowa	0.8395
Kansas	0.7964

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Kentucky	0.8079
Louisiana	0.7637
Maine	0.8754
Maryland	0.8855
Massachusetts	1.1257
Michigan	0.8944
Minnesota	0.9249
Mississippi	0.7746
Missouri	0.8093
Montana	0.8567
Nebraska	0.8283
Nevada	0.9519
New Hampshire	0.9882

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
New Jersey [1]	.....
New Mexico	0.8645
New York	0.8633
North Carolina	0.8714
North Dakota	0.7830
Ohio	0.8675
Oklahoma	0.7664
Oregon	1.0408
Pennsylvania	0.8525
Puerto Rico	0.4400
Rhode Island [1]	.....
South Carolina	0.8607
South Dakota	0.7895

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Tennessee	0.7873
Texas	0.7752
Utah	0.9426
Vermont	0.9402
Virginia	0.8494
Washington	1.0274
West Virginia	0.8053
Wisconsin	0.9229
Wyoming	0.8890

[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 W CC	3.7174	8.1	11.2
2	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9613	4.0	5.2
3	01	SURG	*CRANIOTOMY AGE 0-17	1.9441	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.2960	4.5	7.2
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.3846	2.1	3.1
6	01	SURG	CARPAL TUNNEL RELEASE	.8237	2.1	2.9
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.5718	6.5	9.8
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.4925	1.9	2.8
9	01	MED	SPINAL DISORDERS & INJURIES	1.3592	4.6	6.6
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2507	4.9	6.6
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8629	3.0	4.0
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8881	4.4	5.9
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7928	4.1	5.0
14	01	MED	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1.2742	4.8	6.2
15	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	.9844	4.0	5.0
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2389	4.7	6.2
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6651	2.5	3.1
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9712	4.2	5.4
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6939	2.8	3.5
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7921	8.0	10.8
21	01	MED	VIRAL MENINGITIS	1.5323	5.0	6.6
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0334	3.9	5.0
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8214	3.1	4.3
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9953	3.6	4.9
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.6061	2.5	3.2
26	01	MED	SEIZURE & HEADACHE AGE 0-17	.7854	2.5	4.7
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3045	3.2	5.0
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3318	4.5	6.3
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.7069	2.7	3.6
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3288	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8787	3.0	4.1
32	01	MED	CONCUSSION AGE >17 W/O CC	.5318	1.9	2.4
33	01	MED	*CONCUSSION AGE 0-17	.2066	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	.9962	3.7	5.1
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6353	2.5	3.2
36	02	SURG	RETINAL PROCEDURES	.6814	1.2	1.5
37	02	SURG	ORBITAL PROCEDURES	1.0534	2.6	3.8
38	02	SURG	PRIMARY IRIS PROCEDURES	.5412	1.9	2.5
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5924	1.5	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8647	2.5	3.6
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3348	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6552	1.7	2.4
43	02	MED	HYPHEMA	.4951	2.4	3.0
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6374	4.1	5.1
45	02	MED	NEUROLOGICAL EYE DISORDERS	.7064	2.6	3.2

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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
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7810	3.4	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.5193	2.5	3.2
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0-17	.2949	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7706	3.3	4.6
50	03	SURG	SIALOADENECTOMY	.8318	1.5	1.8
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.9325	1.9	3.1
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8003	1.5	1.9
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.1968	2.1	3.4
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0-17	.4779	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.9492	1.9	3.0
56	03	SURG	RHINOPLASTY	.9678	2.0	3.0
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.9849	2.4	3.7
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	.2714	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.7530	1.8	2.6
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2067	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.3030	2.9	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0-17	.2927	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.4279	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3100	4.4	6.6
65	03	MED	DYSEQUILIBRIUM	.5487	2.3	2.8
66	03	MED	EPISTAXIS	.5626	2.4	3.1
67	03	MED	EPIGLOTTITIS	.7763	2.8	3.6
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6690	3.1	3.8
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5033	2.4	3.0
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.4570	2.8	3.5
71	03	MED	LARYNGOTRACHEITIS	.6933	2.8	3.4
72	03	MED	NASAL TRAUMA & DEFORMITY	.7159	2.6	3.6
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7961	3.2	4.4
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3326	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.0978	7.7	10.1
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8553	8.5	11.4
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2070	3.5	4.9
78	04	MED	PULMONARY EMBOLISM	1.2980	5.7	6.7
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6199	6.7	8.5
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.8747	4.4	5.5
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5059	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3926	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9653	4.3	5.5
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5109	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2119	4.8	6.4
86	04	MED	PLEURAL EFFUSION W/O CC	.6963	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3625	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9039	4.1	5.1
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0431	4.8	5.9
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6270	3.4	4.0
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.6854	3.2	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2255	5.0	6.4
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7331	3.3	4.1
94	04	MED	PNEUMOTHORAX W CC	1.1575	4.7	6.4
95	04	MED	PNEUMOTHORAX W/O CC	.5895	2.9	3.7
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7541	3.7	4.6
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5602	2.9	3.5
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	.9319	3.7	5.1
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.7022	2.4	3.2
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5347	1.7	2.1
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8567	3.3	4.4
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5447	2.0	2.6
103	PRE	SURG	HEART TRANSPLANT	19.5361	29.7	49.4
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.9615	12.3	14.4
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.7856	8.3	10.0
106	05	SURG	CORONARY BYPASS W PTCA	7.4493	9.6	11.4
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3894	9.2	10.5

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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
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.4585	7.8	10.3
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9756	6.8	7.7
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0985	6.5	9.1
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4445	3.5	4.4
112	05	SURG	NO LONGER VALID	.0000	.0	.0
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.9028	10.4	13.4
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6530	6.2	8.5
115	05	SURG	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GN.	3.4452	5.9	8.3
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3075	3.2	4.5
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3312	2.6	4.2
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5696	1.9	2.9
119	05	SURG	VEIN LIGATION & STRIPPING	1.3027	3.0	5.1
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2337	5.3	8.8
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.5813	5.3	6.6
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0393	3.0	3.8
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5526	2.8	4.7
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4301	3.3	4.4
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0846	2.1	2.7
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6971	9.5	12.2
127	05	MED	HEART FAILURE & SHOCK	1.0027	4.1	5.3
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7241	4.7	5.5
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0803	1.8	2.8
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9384	4.5	5.7
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5683	3.3	4.1
132	05	MED	ATHEROSCLEROSIS W CC	.6540	2.3	3.0
133	05	MED	ATHEROSCLEROSIS W/O CC	.5359	1.8	2.3
134	05	MED	HYPERTENSION	.5884	2.5	3.2
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	.8961	3.3	4.5
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5709	2.1	2.6
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.8113	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8249	3.1	4.0
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5128	2.0	2.5
140	05	MED	ANGINA PECTORIS	.5384	2.1	2.6
141	05	MED	SYNCOPE & COLLAPSE W CC	.7284	2.8	3.6
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5605	2.1	2.6
143	05	MED	CHEST PAIN	.5394	1.7	2.1
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1931	3.8	5.5
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.5881	2.1	2.7
146	06	SURG	RECTAL RESECTION W CC	2.7193	8.8	10.2
147	06	SURG	RECTAL RESECTION W/O CC	1.5566	5.8	6.4
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4444	10.2	12.3
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5247	5.9	6.5
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8477	9.1	11.2
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3334	4.5	5.7
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9467	6.9	8.3
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1736	4.8	5.4
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1397	9.8	13.2
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3054	3.0	4.0
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8355	6.0	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2618	3.9	5.6
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6504	2.0	2.5
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3593	3.7	5.1
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.8070	2.2	2.7
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1278	2.8	4.2
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6337	1.6	1.9

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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
163	06	SURG	*HERNIA PROCEDURES AGE 0-17	.6855	2.1	2.1
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.2964	7.0	8.3
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2622	4.0	4.7
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4680	3.7	4.9
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.9104	2.1	2.5
168	03	SURG	MOUTH PROCEDURES W CC	1.2974	3.3	4.9
169	03	SURG	MOUTH PROCEDURES W/O CC	.7397	1.8	2.3
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8017	7.4	11.0
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1651	3.1	4.3
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3567	5.1	7.0
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7531	2.7	3.8
174	06	MED	G.I. HEMORRHAGE W CC	.9937	3.9	4.8
175	06	MED	G.I. HEMORRHAGE W/O CC	.5553	2.5	2.9
176	06	MED	COMPLICATED PEPTIC ULCER	1.0832	4.1	5.3
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.9193	3.7	4.5
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6843	2.6	3.1
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0778	4.6	6.0
180	06	MED	G.I. OBSTRUCTION W CC	.9429	4.2	5.4
181	06	MED	G.I. OBSTRUCTION W/O CC	.5322	2.8	3.4
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7982	3.3	4.4
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5722	2.3	2.9
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.4806	2.3	2.8
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8998	3.3	4.7
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	.3185	2.9	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.8564	3.0	4.1
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0955	4.1	5.6
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5821	2.4	3.1
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.6986	3.3	4.8
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.2962	9.8	13.8
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6932	4.7	6.1
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4015	10.4	12.8
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6023	5.5	6.9
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0046	8.6	10.4
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6036	4.6	5.4
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4858	7.3	9.0
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2276	3.8	4.4
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4260	7.0	9.9
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.9570	6.5	10.5
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7421	10.3	14.5
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.2879	4.8	6.4
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3499	5.0	6.8
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1826	4.4	5.8
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.1933	4.6	6.2
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.7038	3.0	3.9
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1338	4.0	5.3
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6526	2.3	2.9
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0531	4.5	5.0
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8289	6.1	7.0
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2715	4.6	5.0
212	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	.8391	11.1	11.1
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.8664	6.6	9.2
214	08	SURG	NO LONGER VALID	.0000	.0	.0
215	08	SURG	NO LONGER VALID	.0000	.0	.0

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DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.2151	6.6	9.6
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	3.0062	9.1	13.4
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.5404	4.3	5.4
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	1.0244	2.7	3.2
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17.	.5789	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.	1.0248	2.1	2.9
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	.7868	1.6	1.9
225	08	SURG	FOOT PROCEDURES	1.1460	3.4	5.0
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5663	4.6	6.7
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8129	2.1	2.7
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.1339	2.6	4.1
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.6984	1.7	2.2
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.2657	3.3	5.1
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3977	3.1	4.9
232	08	SURG	ARTHROSCOPY	1.0021	1.8	2.7
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9862	4.8	7.2
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.2329	2.3	3.2
235	08	MED	FRACTURES OF FEMUR	.7648	3.8	5.1
236	08	MED	FRACTURES OF HIP & PELVIS	.7233	4.0	4.9
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5797	2.9	3.6
238	08	MED	OSTEOMYELITIS	1.3934	6.6	8.9
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0031	4.9	6.3
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3301	5.0	6.7
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6493	3.1	3.9
242	08	MED	SEPTIC ARTHRITIS	1.1093	5.1	6.7
243	08	MED	MEDICAL BACK PROBLEMS	.7407	3.7	4.7
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7056	3.7	4.7
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4686	2.7	3.4
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5658	2.9	3.8
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5725	2.6	3.4
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.8317	3.8	4.9
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6895	2.5	3.7
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6886	3.3	4.2
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4624	2.2	2.8
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.2513	1.8	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	.7384	3.7	4.7
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	.4433	2.6	3.1
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.2928	2.9	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.8038	3.8	5.1
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.8995	2.1	2.7
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7107	1.6	1.8
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.9130	1.7	2.7
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6821	1.2	1.4
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9773	1.6	2.2
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.9324	2.9	4.3

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DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.2113	9.3	12.5
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1350	5.5	7.1
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5906	4.2	6.7
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8540	2.2	3.1
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9343	2.5	4.3
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1068	2.4	3.6
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6798	5.7	8.2
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7495	2.3	3.3
271	09	MED	SKIN ULCERS	1.0266	5.6	7.3
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0013	4.6	6.1
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.5578	3.0	3.9
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1936	4.8	6.8
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5469	2.2	3.0
276	09	MED	NON-MALIGANT BREAST DISORDERS	.6781	3.5	4.5
277	09	MED	CELLULITIS AGE >17 W CC	.8580	4.7	5.8
278	09	MED	CELLULITIS AGE >17 W/O CC	.5497	3.6	4.3
279	09	MED	*CELLULITIS AGE 0-17	.6580	4.2	4.2
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6972	3.2	4.2
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4634	2.3	2.9
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.2545	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	.7211	3.5	4.7
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4300	2.4	3.1
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	2.0391	8.0	10.6
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.0831	4.5	5.9
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8701	7.7	10.6
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.2124	4.3	5.4
289	10	SURG	PARATHYROID PROCEDURES	.9697	1.8	2.8
290	10	SURG	THYROID PROCEDURES	.8955	1.7	2.2
291	10	SURG	THYROGLOSSAL PROCEDURES	.6333	1.4	1.6
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4623	6.8	10.0
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2998	3.3	4.9
294	10	MED	DIABETES AGE >35	.7573	3.4	4.5
295	10	MED	DIABETES AGE 0-35	.7854	3.0	4.0
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8469	3.9	5.1
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5046	2.7	3.4
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.5879	2.9	4.4
299	10	MED	INBORN ERRORS OF METABOLISM	.9367	3.8	5.4
300	10	MED	ENDOCRINE DISORDERS W CC	1.0930	4.7	6.2
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6308	2.8	3.7
302	11	SURG	KIDNEY TRANSPLANT	3.2671	7.4	8.7
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.4195	6.7	8.3
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3243	6.2	8.7
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1946	2.9	3.6
306	11	SURG	PROSTATECTOMY W CC	1.2725	3.6	5.5
307	11	SURG	PROSTATECTOMY W/O CC	.6329	1.8	2.2
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6399	4.0	6.3
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8980	1.7	2.2
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1281	2.9	4.3
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6270	1.5	1.8
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0583	3.0	4.5
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6693	1.7	2.1
314	11	SURG	*URETHRAL PROCEDURES, AGE 0-17	.4905	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0954	3.8	7.2
316	11	MED	RENAL FAILURE	1.3241	4.9	6.6
317	11	MED	ADMIT FOR RENAL DIALYSIS	.6603	2.0	3.1
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1819	4.4	6.1
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6051	2.1	2.9
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8555	4.3	5.3

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321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5645	3.1	3.8
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.4769	3.1	3.7
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.8049	2.4	3.1
324	11	MED	URINARY STONES W/O CC	.4643	1.5	1.8
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC ...	.6508	2.9	3.8
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4441	2.2	2.7
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.3668	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7339	2.8	3.8
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4891	1.7	2.2
330	11	MED	*URETHRAL STRICTURE AGE 0-17	.3160	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0553	4.2	5.6
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5998	2.4	3.2
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.7662	3.3	4.7
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5217	4.0	4.8
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1249	2.9	3.2
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8721	2.6	3.4
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6046	1.8	2.1
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2297	3.5	5.6
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1006	2.9	4.6
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.2808	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.2148	1.9	3.1
342	12	SURG	CIRCUMCISION AGE >17	.7897	2.3	3.1
343	12	SURG	*CIRCUMCISION AGE 0-17	.1526	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.2631	1.6	2.4
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1839	2.9	4.8
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0453	4.5	6.0
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5654	2.0	2.7
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7111	3.2	4.2
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.3943	1.9	2.5
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.7192	3.6	4.5
351	12	MED	*STERILIZATION, MALE	.2342	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.7227	2.8	4.0
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8746	5.0	6.5
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5439	4.8	5.8
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9119	3.0	3.2
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7675	1.9	2.2
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3212	6.7	8.4
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2295	3.5	4.3
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8356	2.4	2.6
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8857	2.3	2.8
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1215	2.3	3.7
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.2993	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.8801	2.6	3.6
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.8399	2.7	3.9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9401	5.2	7.7
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2804	4.9	6.9
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5388	2.3	3.0
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.2019	5.2	6.7
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5941	2.4	3.2
370	14	SURG	CESAREAN SECTION W CC	.9721	4.4	5.7
371	14	SURG	CESAREAN SECTION W/O CC	.6742	3.3	3.6
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.6053	2.6	3.7
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3931	2.0	2.3
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7855	2.5	2.9
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.5714	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.4827	2.6	3.5

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377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.4673	3.2	4.4
378	14	MED	ECTOPIC PREGNANCY	.8385	2.0	2.5
379	14	MED	THREATENED ABORTION	.3944	2.1	3.0
380	14	MED	ABORTION W/O D&C	.3662	1.6	2.0
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.5859	1.6	2.1
382	14	MED	FALSE LABOR	.1588	1.2	1.4
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.5475	2.7	4.0
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.4188	1.8	2.7
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3636	1.8	1.8
386	15	MED	*EXTREME IMMATURITY	4.4966	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.0711	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8531	8.6	8.6
389	15	MED	*FULL TERM NEONATE W MAJOR PROBLEMS	3.1546	4.7	4.7
390	15	MED	*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1165	3.4	3.4
391	15	MED	*NORMAL NEWBORN	.1512	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.1530	6.9	9.5
393	16	SURG	*SPLENECTOMY AGE 0-17	1.3357	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.7961	4.3	7.0
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8141	3.2	4.4
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	.6515	2.4	3.8
397	16	MED	COAGULATION DISORDERS	1.2348	3.7	5.2
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2646	4.6	5.9
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6883	2.8	3.6
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6627	5.5	9.0
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.7815	8.0	11.3
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1184	2.7	3.9
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7630	5.7	8.0
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8543	3.0	4.2
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.8937	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7896	6.9	9.7
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2754	3.3	4.1
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.0472	4.7	7.9
409	17	MED	RADIOTHERAPY	1.2026	4.5	6.1
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.0423	3.1	4.0
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3885	2.2	2.9
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.2791	1.6	2.0
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3594	5.3	7.3
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.6897	3.0	4.0
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6521	10.4	14.5
416	18	MED	SEPTICEMIA AGE >17	1.5936	5.6	7.5
417	18	MED	SEPTICEMIA AGE 0-17	1.1657	4.5	6.1
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0377	4.8	6.2
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8636	3.6	4.7
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.5907	2.8	3.4
421	18	MED	VIRAL ILLNESS AGE >17	.7028	2.9	3.8
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.4351	2.3	2.9
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7883	5.9	8.3
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.2964	8.1	13.0
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	.6796	2.9	3.9
426	19	MED	DEPRESSIVE NEUROSES	.5177	3.2	4.5
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5199	3.1	4.4
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7376	4.4	7.4
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8268	4.7	6.3
430	19	MED	PSYCHOSES	.7128	5.7	8.0
431	19	MED	CHILDHOOD MENTAL DISORDERS	.5925	4.2	5.9
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.6333	2.9	4.6

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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
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2752	2.2	3.0
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	1.6840	5.4	8.5
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9031	5.7	9.0
441	21	SURG	HAND PROCEDURES FOR INJURIES	.9231	2.1	3.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4078	5.6	8.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0670	2.6	3.5
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7577	3.2	4.3
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4857	2.3	2.9
446	21	MED	*TRAUMATIC INJURY AGE 0-17	.2936	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	.5000	1.8	2.4
448	21	MED	*ALLERGIC REACTIONS AGE 0-17	.0965	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8233	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4272	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.2607	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0378	3.5	5.0
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5133	2.1	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8272	3.0	4.4
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4542	1.8	2.4
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.	1.1927	2.2	4.1
462	23	MED	REHABILITATION	1.1251	9.3	11.5
463	23	MED	SIGNS & SYMPTOMS W CC	.6930	3.2	4.2
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4957	2.4	3.0
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6785	1.8	2.9
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.7305	2.1	3.9
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.6095	2.1	8.4
468	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6658	9.2	13.0
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.	3.0990	4.8	5.5
472	22	SURG	NO LONGER VALID	.0000	.0	.0
473	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5075	7.3	12.6
474	04	SURG	NO LONGER VALID	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6408	8.0	11.3
476	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2587	8.0	11.3
477	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8605	5.3	8.2
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3660	4.9	7.4
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4314	2.5	3.3
480	PRE	SURG	LIVER TRANSPLANT	10.1911	15.7	21.5
481	PRE	SURG	BONE MARROW TRANSPLANT	6.9570	19.3	22.0
482	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.4938	9.7	12.5
483	PRE	SURG	TRACHEOSTOMY/MECH VENT 96+HRS EXCEPT FACE,MOUTH & NECK DIAGNOSES.	16.2670	34.6	42.0
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5512	8.9	13.2
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	2.9897	7.6	9.5
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8066	8.4	12.4
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9538	5.5	7.8
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.6394	11.5	16.9
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7885	6.0	8.6

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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
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0200	3.7	5.3
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.7021	2.9	3.5
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	3.9117	9.2	15.0
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8188	4.3	5.9
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0128	1.9	2.5
495	PRE	SURG	LUNG TRANSPLANT	8.9713	14.3	17.2
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.7699	7.1	9.5
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.3834	5.4	6.5
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.4714	3.7	4.1
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4381	3.4	4.6
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9487	2.0	2.5
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.5940	8.4	10.7
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5391	5.3	6.4
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2111	2.9	3.9
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	14.4707	26.9	35.1
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	1.9872	2.2	3.7
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.6264	12.7	17.3
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.7118	6.5	9.0
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.4160	5.8	8.4
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.9410	4.1	5.5
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2161	4.6	6.7
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.6968	3.0	4.4
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.7000	11.7	14.2
513	PRE	SURG	PANCREAS TRANSPLANT	6.1951	9.4	10.7
514	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH	6.3288	5.0	7.3
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.0380	3.3	5.5
516	05	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.7295	3.7	4.7
517	05	SURG	PERC CARDIO PROC W CORONARY ARTERY STENT W/O AMI	2.1793	1.9	2.6
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7267	2.3	3.4
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.3467	3.2	5.2
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.5390	1.7	2.1
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	.7267	4.3	5.8
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	.5829	7.5	9.5
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	.4007	3.3	4.1
524	01	MED	TRANSIENT ISCHEMIA	.7236	2.7	3.4
525	05	SURG	HEART ASSIST SYSTEM IMPLANT	11.3787	9.3	16.2

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TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
040.82	Toxic shock syndrome	Y	18	423
066.4	West Nile fever	N	18	421, 422
277.02	Cystic fibrosis with pulmonary manifestations	Y	4	79, 80, 81
277.03	Cystic fibrosis with gastrointestinal manifestations	Y	6	188, 189, 190
277.09	Cystic fibrosis with other manifestations	Y	10	296, 297, 298
357.81	Chronic inflammatory demyelinating polyneuritis	N	1	18, 19
357.82	Critical illness polyneuropathy	N	1	18, 19
357.89	Other inflammatory and toxic neuropathy	N	1	18, 19
359.81	Critical illness myopathy	N	1	34, 35
359.89	Other myopathies	N	1	34, 35
365.83	Aqueous misdirection	N	2	46, 47, 48
414.06	Coronary atherosclerosis of coronary artery of transplanted heart	N	5	132, 133

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
414.12	Dissection of coronary artery	N	5	121, 144, 145
428.20	Unspecified systolic heart failure	Y	5	115, 121, 124, 127
428.21	Acute systolic heart failure	Y	5	115, 121, 124, 127
428.22	Chronic systolic heart failure	Y	5	115, 121, 124, 127
428.23	Acute on chronic systolic heart failure	Y	5	115, 121, 124, 127
428.30	Unspecified diastolic heart failure	Y	5	115, 121, 124, 127
428.31	Acute diastolic heart failure	Y	5	115, 121, 124, 127
428.32	Chronic diastolic heart failure	Y	5	115, 121, 124, 127
428.33	Acute on chronic diastolic heart failure	Y	5	115, 121, 124, 127
428.40	Unspecified combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.41	Acute combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.42	Chronic combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.43	Acute on chronic combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
438.6	Alterations of sensations	N	1	12
438.7	Disturbances of vision	N	1	12
438.83	Facial weakness	N	1	12
438.84	Ataxia	N	1	12
438.85	Vertigo	N	1	12
443.21	Dissection of carotid artery	N	5	130, 131
443.22	Dissection of iliac artery	N	5	130, 131
443.23	Dissection of renal artery	N	11	331, 332, 333
443.24	Dissection of vertebral artery	N	5	130, 131
443.29	Dissection of other artery	N	5	130, 131
445.01	Atheroembolism, upper extremity	Y	5	130, 131
445.02	Atheroembolism, lower extremity	Y	5	130, 131
445.81	Atheroembolism, kidney	Y	11	331, 332, 333
445.89	Atheroembolism, other site	Y	5	130, 131
454.8	Varicose veins of the lower extremities, with other complications	N	5	130, 131
459.10	Postphlebetic syndrome without complications	N	5	130, 131
459.11	Postphlebetic syndrome with ulcer	N	5	130, 131
459.12	Postphlebetic syndrome with inflammation	N	5	130, 131
459.13	Postphlebetic syndrome with ulcer and inflammation	N	5	130, 131
459.19	Postphlebetic syndrome with other complication	N	5	130, 131
459.30	Chronic venous hypertension without complications	N	5	130, 131
459.31	Chronic venous hypertension with ulcer	N	5	130, 131
459.32	Chronic venous hypertension with inflammation	N	5	130, 131
459.33	Chronic venous hypertension with ulcer and inflammation	N	5	130, 131
459.39	Chronic venous hypertension with other complication	N	5	130, 131
537.84	Dieulafoy lesion (hemorrhagic) of stomach and duodenum	Y	6	174, 175
569.86	Dieulafoy lesion (hemorrhagic) of intestine	Y	6	188, 189, 190
633.00	Abdominal pregnancy without intrauterine pregnancy	N	14	378
633.01	Abdominal pregnancy with intrauterine pregnancy	N	14	378
633.10	Tubal pregnancy without intrauterine pregnancy	N	14	378
633.11	Tubal pregnancy with intrauterine pregnancy	N	14	378
633.20	Ovarian pregnancy without intrauterine pregnancy	N	14	378
633.21	Ovarian pregnancy with intrauterine pregnancy	N	14	378
633.80	Other ectopic pregnancy without intrauterine pregnancy	N	14	378
633.81	Other ectopic pregnancy with intrauterine pregnancy	N	14	378
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	N	14	378
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy	N	14	378
747.83	Persistent fetal circulation	N	15	387, 389
765.20	Unspecified weeks of gestation	N	15	391
765.21	Less than 24 completed weeks of gestation	N	15	386
765.22	24 completed weeks of gestation	N	15	386
765.23	25-26 completed weeks of gestation	N	15	386
765.24	27-28 completed weeks of gestation	N	15	387, 388
765.25	29-30 completed weeks of gestation	N	15	387, 388
765.26	31-32 completed weeks of gestation	N	15	387, 388
765.27	33-34 completed weeks of gestation	N	15	387, 388
765.28	35-36 completed weeks of gestation	N	15	387, 388
765.29	37 or more completed weeks of gestation	N	15	391
770.81	Primary apnea of newborn	N	15	390
770.82	Other apnea of newborn	N	15	390
770.83	Cyanotic attacks of newborn	N	15	390
770.84	Respiratory failure of newborn	Y	15	387, 389
770.89	Other respiratory problems after birth	N	15	390
771.81	Septicemia [sepsis] of newborn	Y	15	387, 389
771.82	Urinary tract infection of newborn	N	15	387, 389
771.83	Bacteremia of newborn	Y	15	387, 389
771.89	Other infections specific to the perinatal period	N	15	387, 389
779.81	Neonatal bradycardia	N	15	390

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
779.82	Neonatal tachycardia	N	15	390
779.89	Other specified conditions originating in the perinatal period	N	15	390
780.91	Fussy infant (baby)	N	23	463,464
780.92	Excessive crying of infant (baby)	N	23	463,464
780.99	Other general symptoms	N	23	463,464
781.93	Ocular torticollis	N	8	243
795.00	Nonspecific abnormal Papanicolaou smear of cervix, unspecified	N	13	358, 359, 369
795.01	Atypical squamous cell changes of undetermined significance favor benign (ASCUS favor benign)	N	13	358, 359, 369
795.02	Atypical squamous cell changes of undetermined significance favor dysplasia (ASCUS favor dysplasia)	N	13	358, 359, 369
795.09	Other nonspecific abnormal Papanicolaou smear of cervix	N	13	358, 359, 369
795.31	Nonspecific positive findings for anthrax	N	18	423
795.39	Other nonspecific positive culture findings	N	18	423
813.45	Torus fracture of radius	N	8	250, 251, 252
			24	487
823.40	Torus fracture, tibia alone	N	8	253, 254, 255
			24	487
823.41	Torus fracture, fibula alone	N	8	253, 254, 255
			24	487
823.42	Torus fracture, fibula with tibia	N	8	253, 254, 255
			24	487
995.90	Systemic inflammatory response syndrome, unspecified	Y	18	416, 417
995.91	Systemic inflammatory response syndrome due to infectious process without organ dysfunction	Y	18	416, 417
995.92	Systemic inflammatory response syndrome due to infectious process with organ dysfunction	Y	18	416, 417
995.93	Systemic inflammatory response syndrome due to non-infectious process without organ dysfunction	Y	18	416, 417
995.94	Systemic inflammatory response syndrome due to non-infectious process with organ dysfunction	Y	18	416, 417
998.31	Disruption of internal operation wound	Y	21	452, 453
998.32	Disruption of external operation wound	Y	21	452, 453
V01.81	Contact with or exposure to communicable diseases, anthrax	N	15	391 [1]
			23	467
V01.89	Contact with or exposure to communicable diseases, other communicable diseases	N	15	391 [1]
			23	467
V13.21	Personal history of pre-term labor	N	23	467
V13.29	Personal history of other genital system and obstetric disorders	N	23	467
V23.41	Pregnancy with history of pre-term labor	N	14	469
V23.49	Pregnancy with other poor obstetric history	N	14	469
V46.2	Other dependence on machines, supplemental oxygen	N	23	467
V54.10	Aftercare for healing traumatic fracture of arm, unspecified	N	8	249
V54.11	Aftercare for healing traumatic fracture of upper arm	N	8	249
V54.12	Aftercare for healing traumatic fracture of lower arm	N	8	249
V54.13	Aftercare for healing traumatic fracture of hip	N	8	249
V54.14	Aftercare for healing traumatic fracture of leg, unspecified	N	8	249
V54.15	Aftercare for healing traumatic fracture of upper leg	N	8	249
V54.16	Aftercare for healing traumatic fracture of lower leg	N	8	249
V54.17	Aftercare for healing traumatic fracture of vertebrae	N	8	249
V54.19	Aftercare for healing traumatic fracture of other bone	N	8	249
V54.20	Aftercare for healing pathologic fracture of arm, unspecified	N	8	249
V54.21	Aftercare for healing pathologic fracture of upper arm	N	8	249
V54.22	Aftercare for healing pathologic fracture of lower arm	N	8	249
V54.23	Aftercare for healing pathologic fracture of hip	N	8	249
V54.24	Aftercare for healing pathologic fracture of leg, unspecified	N	8	249
V54.25	Aftercare for healing pathologic fracture of upper leg	N	8	249
V54.26	Aftercare for healing pathologic fracture of lower leg	N	8	249
V54.27	Aftercare for healing pathologic fracture of vertebrae	N	8	249
V54.29	Aftercare for healing pathologic fracture of other bone	N	8	249
V54.81	Aftercare following joint replacement	N	8	249
V54.89	Other orthopedic aftercare	N	8	249
V58.42	Aftercare following surgery for neoplasm	N	23	465,466
V58.43	Aftercare following surgery for injury and trauma	N	23	465,466
V58.71	Aftercare following surgery of the sense organs, NEC	N	23	465,466
V58.72	Aftercare following surgery of the nervous system, NEC	N	23	465,466
V58.73	Aftercare following surgery of the circulatory system, NEC	N	23	465,466
V58.74	Aftercare following surgery of the respiratory system, NEC	N	23	465,466
V58.75	Aftercare following surgery of the teeth, oral cavity and digestive system, NEC	N	23	465,466

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V58.76	Aftercare following surgery of the genitourinary system, NEC	N	23	465,466
V58.77	Aftercare following surgery of the skin and subcutaneous tissue, NEC	N	23	465,466
V58.78	Aftercare following surgery of the musculoskeletal system, NEC	N	23	465,466
V71.82	Observation and evaluation for suspected exposure to anthrax	N	23	467
V71.83	Observation and evaluation for suspected exposure to other biological agent	N	23	467
V83.81	Cystic fibrosis gene carrier	N	23	467
V83.89	Other genetic carrier status	N	23	467

[1] Classified as an ''only secondary diagnosis'' in this DRG.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
00.01	Therapeutic ultrasound of vessels of head and neck	N		
00.02	Therapeutic ultrasound of heart	N		
00.03	Therapeutic ultrasound of peripheral vascular vessels	N		
00.09	Other therapeutic ultrasound	N		
00.10	Implantation of chemotherapeutic agent	N		
00.11	Infusion of drotrecogin alfa (activated)	N		
00.12	Administration of inhaled nitric oxide	N		
00.13	Injection or infusion of nesiritide	N		
00.14	Injection or infusion of oxazolidinone class of antibiotics	N		
00.50	Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT-P]	Y	5	115[1], 116[1]
00.51	Implantation of cardiac resynchronization defibrillator, total system [CRT-D]	Y	5	514[1], 515[1]
00.52	Implantation or replacement of transvenous lead (electrode) into left ventricular coronary venous system	Y	5	115[2], 116[3], 514[4], 515[4]
00.53	Implantation or replacement of cardiac resynchronization pacemaker pulse generator only [CRT-P]	Y	5	115[2], 116[3], 118
00.54	Implantation or replacement of cardiac resynchronization defibrillator pulse generator only [CRT-D]	Y	5	115[1], 514[4], 515[4]
00.55	Insertion of drug-eluting noncoronary artery stent(s)	N		
36.07	Insertion of drug-eluting coronary artery stents(s)	N*	5	517
39.72	Endovascular repair or occlusion of head and neck vessels	Y	1	1,2,3
			5	110, 111
			11	315
			21	442, 443
			24	486
49.75	Implantation or revision of artificial anal sphincter	Y	6	157, 158
			9	267
			21	442, 443
			24	486
49.76	Removal of artificial anal sphincter	Y	6	157, 158
			9	267
			21	442, 443
			24	486
81.61	360 degree spinal fusion, single incision approach	Y	1	4
			8	496
			21	442, 443
			24	486
84.51	Insertion of interbody spinal fusion device	N		
84.52	Insertion of recombinant bone morphogenetic protein	N		
88.96	Other intraoperative magnetic resonance imaging	N		
99.76	Extracorporeal immunoadsorption	N		
99.77	Application or administration of an adhesion barrier substance	N		

*Non-operating room procedure, but affects DRG.
[1] Classified under ''operating room procedures''.
[2] Classified under ''operating room procedure'' and under ''as any of the following procedure combinations'' as 00.52 and 00.53.
[3] Classified under ''any of the following procedure combinations'' as 00.52 and 00.53.
[4] Classified under ''any of the following procedure combinations'' as 00.52 and 00.54.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
357.8	Other inflammatory and toxic neuropathy	N	1	18, 19
359.8	Other myopathies	N	1	34, 35

TABLE 6C.—INVALID DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
459.1	Postphlebetic syndrome	N	5	130, 131
633.0	Abdominal pregnancy	N	14	378
633.1	Tubal pregnancy	N	14	378
633.2	Ovarian pregnancy	N	14	378
633.8	Other ectopic pregnancy	N	14	378
633.9	Unspecified ectopic pregnancy	N	14	378
770.8	Other respiratory problems after birth	N	15	387, 389
771.8	Other infections specific to the perinatal period	Y	15	387, 389
779.8	Other specified conditions originating in the perinatal period	N	15	390
780.9	Other general symptoms	N	23	463, 464
795.0	Nonspecific abnormal Papanicolaou smear of cervix	N	13	358, 359, 369
795.3	Nonspecific positive culture findings	N	18	423
998.3	Disruption of operation wound	Y	21	452, 453
V01.8	Other communicable diseases	N	23	467
V13.2	Other genital system and obstetric disorders	N	23	467
V23.4	Pregnancy with other poor obstetric history	N	14	469
V54.8	Other orthopedic aftercare	N	8	249

TABLE 6D.—INVALID PROCEDURE CODES

Note: There are no invalid procedure codes for FY 2003.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
402.00	Hypertensive heart disease, malignant, without heart failure	Y	5	134
402.01	Hypertensive heart disease, malignant, with heart failure	Y	5	115, 121, 124, 127
402.10	Hypertensive heart disease, benign, without heart failure	N	5	134
402.11	Hypertensive heart disease, benign, with heart failure	Y	5	115, 121, 124, 127
402.90	Hypertensive heart disease, unspecified, without heart failure	N	5	134
402.91	Hypertensive heart disease, unspecified, with heart failure	Y	5	115, 121, 124, 127
404.00	Hypertensive heart and renal disease, malignant, without mention of heart failure or renal failure	Y	5	134
404.01	Hypertensive heart and renal disease, malignant, with heart failure	Y	5	115, 121, 124, 127
404.03	Hypertensive heart and renal disease, malignant, with heart failure and renal failure	Y	5	115, 121, 124, 127
404.10	Hypertensive heart and renal disease, benign, without mention of heart failure or renal failure	N	5	134
404.11	Hypertensive heart and renal disease, benign, with heart failure	Y	5	115, 121, 124, 127
404.13	Hypertensive heart and renal disease, benign, with heart failure and renal failure	Y	5	115, 121, 124, 127
404.90	Hypertensive heart and renal disease, unspecified, without mention of heart failure or renal failure	N	5	134
404.91	Hypertensive heart and renal disease, unspecified, with heart failure	Y	5	115, 121, 124, 127
404.93	Hypertensive heart and renal disease, unspecified, with heart failure and renal failure	Y	5	115, 121, 124, 127
414.10	Aneurysm of heart	N	5	121, 144, 145
414.11	Aneurysm of coronary vessels	N	5	121, 144, 145
414.19	Other aneurysm of heart	N	5	121, 144, 145
428.0	Congestive heart failure, unspecified	Y	5	115, 121, 124, 127
454.9	Asymptomatic varicose veins	N	5	130, 131
627.2	Symptomatic menopausal or female climacteric states	N	13	358, 359, 369
627.4	Symptomatic states associated with artificial menopause	N	13	358, 359, 369
V49.81	Asymptomatic postmenopausal status (age-related) (natural)	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
36.06	Insertion of nondrug-eluting coronary artery stents(s)	N*	5	517
39.79	Other endovascular repair of aneurysm of other vessels	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443

TABLE 6F.—REVISED PROCEDURE CODE TITLES—Continued

Procedure code	Description	OR	MDC	DRG
39.90	Insertion of nondrug-eluting, noncoronary artery stent(s)	N	24	486

*Nonoperating room procedure, but affects DRG.

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*0031	99591	6829	99591	99593	44501	42821	4280
99590	99592	99590	99592	99594	44502	42822	4281
99591	99593	99591	99593	*04186	44581	42823	42820
99592	99594	99592	99594	99590	44589	42830	42821
99593	*03843	99593	*0412	99591	*25090	42831	42822
99594	99590	99594	99590	99592	44501	42832	42823
*0202	99591	*04089	99591	99593	44502	42833	42830
99590	99592	99590	99592	99594	44581	42840	42831
99591	99593	99591	99593	*04189	44589	42841	42832
99592	99594	99592	99594	99590	*25091	42842	42833
99593	*03844	99593	*0413	99591	44501	42843	42840
99594	99590	99594	99590	99592	44502	*40211	42841
*0362	99591	*04100	99591	99593	44581	42820	42842
99590	99592	99590	99592	99594	44589	42821	42843
99591	99593	99591	99593	*0419	*25092	42822	4289
99592	99594	99592	99594	99590	44501	42823	5184
99593	*03849	99593	*0414	99591	44502	42830	*42821
99594	99590	99594	99590	99592	44581	42831	39891
*0380	99591	*04101	99591	99593	44589	42832	40201
99590	99592	99590	99592	99594	*25093	42833	40211
99591	99593	99591	99593	*0545	44501	42840	40291
99592	99594	99592	99594	99590	44502	42841	4280
99593	*0388	99593	*0415	99591	44581	42842	4281
99594	99590	99594	99590	99592	44589	42843	42820
*03810	99591	*04102	99591	99593	*2515	*40291	42821
99590	99592	99590	99592	99594	53784	42820	42822
99591	99593	99591	99593	*1398	56986	42821	42823
99592	99594	99592	99594	99590	*27700	42822	42830
99593	*0389	99593	*0416	99591	27702	42823	42831
99594	99590	99594	99590	99592	27703	42830	42832
*03811	99591	*04103	99591	99593	27709	42831	42833
99590	99592	99590	99592	99594	*27701	42832	42840
99591	99593	99591	99593	*25070	27702	42833	42841
99592	99594	99592	99594	44501	27703	42840	42842
99593	*04082	99593	*0417	44502	27709	42841	42843
99594	0380	99594	99590	44581	*27702	42842	4289
*03819	03810	*04104	99591	44589	27700	42843	5184
99590	03811	99590	99592	*25071	27701	*4280	*42822
99591	03819	99591	99593	44501	27702	42820	39891
99592	0382	99592	99594	44502	27703	42821	40201
99593	0383	99593	*04181	44581	27709	42822	40211
99594	03840	99594	99590	44589	*27703	42823	40291
*0382	03841	*04105	99591	*25072	27700	42830	4280
99590	03842	99590	99592	44501	27701	42831	4281
99591	03843	99591	99593	44502	27702	42832	42820
99592	03844	99592	99594	44581	27703	42833	42821
99593	03849	99593	*04182	44589	27709	42840	42822
99594	0388	99594	99590	*25073	*27709	42841	42823
*0383	0389	*04109	99591	44501	27700	42842	42830
99590	04082	99590	99592	44502	27701	42843	42831
99591	6800	99591	99593	44581	27702	*4281	42832
99592	6801	99592	99594	44589	27703	42820	42833
99593	6802	99593	*04183	*25080	27709	42821	42840
99594	6803	99594	99590	44501	*39891	42822	42841
*03840	6804	*04110	99591	44502	42820	42823	42842
99590	6805	99590	99592	44581	42821	42830	42843
99591	6806	99591	99593	44589	42822	42831	4289
99592	6807	99592	99594	*25081	42823	42832	5184
99593	6808	99593	*04184	44501	42830	42833	*42823
99594	6809	99594	99590	44502	42831	42840	39891
*03841	6820	*04111	99591	44581	42832	42841	40201
99590	6821	99590	99592	44589	42833	42842	40211
99591	6822	99591	99593	*25082	42840	42843	40291
99592	6823	99592	99594	44501	42841	*42820	4280
99593	6825	99593	*04185	44502	42842	39891	4281
99594	6826	99594	99590	44581	42843	40201	42820
*03842	6827	*04119	99591	44589	*40201	40211	42821
99590	6828	99590	99592	*25083	42820	40291	42822

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

42823	5184	42822	42831	56986	*53270	53784	*56202
42830	*42833	42823	42832	*53140	53784	56986	53784
42831	39891	42830	42833	53784	56986	*53411	56986
42832	40201	42831	42840	56986	*53271	53784	*56203
42833	40211	42832	42841	*53141	53784	56986	53784
42840	40291	42833	42842	53784	56986	*53420	56986
42841	4280	42840	42843	56986	*53290	53784	*56212
42842	4281	42841	44501	*53150	53784	56986	53784
42843	42820	42842	44502	53784	56986	*53421	56986
4289	42821	42843	44581	56986	*53291	53784	*56213
5184	42822	4289	44589	*53151	53784	56986	53784
*42830	42823	5184	*4599	53784	56986	*53430	56986
39891	42830	*42843	42820	56986	*53300	53784	*5693
40201	42831	39891	42821	*53160	53784	56986	53784
40211	42832	40201	42822	53784	56986	*53431	56986
40291	42833	40211	42823	56986	*53301	53784	*56985
4280	42840	40291	42830	*53161	53784	56986	53784
4281	42841	4280	42831	53784	56986	*53440	56986
42820	42842	4281	42832	56986	*53310	53784	*56986
42821	42843	42820	42833	*53170	53784	56986	56986
42822	4289	42821	42840	53784	56986	*53441	*5780
42823	5184	42822	42841	56986	*53311	53784	53784
42830	*42840	42823	42842	*53171	53784	56986	56986
42831	39891	42830	42843	53784	56986	*53450	*5781
42832	40201	42831	44501	56986	*53320	53784	53784
42833	40211	42832	44502	*53190	53784	56986	56986
42840	40291	42833	44581	53784	56986	*53451	*5789
42841	4280	42840	44589	56986	*53321	53784	53784
42842	4281	42841	*5184	*53191	53784	56986	56986
42843	42820	42842	42820	53784	56986	*53460	*74783
4289	42821	42843	42821	56986	*53330	53784	42971
5184	42822	4289	42822	*53200	53784	56986	42979
*42831	42823	5184	42823	53784	56986	*53461	7450
39891	42830	*4289	42830	56986	*53331	53784	74510
40201	42831	42820	42831	*53201	53784	56986	74511
40211	42832	42821	42832	53784	56986	*53470	74512
40291	42833	42822	42833	56986	*53340	53784	74519
4280	42840	42823	42840	*53210	53784	56986	7452
4281	42841	42830	42841	53784	56986	*53471	7453
42820	42842	42831	42842	56986	*53341	53784	7454
42821	42843	42832	42843	*53211	53784	56986	74560
42822	4289	42833	*5302	53784	56986	*53490	74569
42823	5184	42840	53784	56986	*53350	53784	7457
42830	*42841	42841	56986	*53220	53784	56986	74601
42831	39891	42842	*5307	53784	56986	*53491	74602
42832	40201	42843	53784	56986	*53351	53784	7461
42833	40211	*44489	56986	*53221	53784	56986	7462
42840	40291	44501	*53082	53784	56986	*53501	7463
42841	4280	44502	53784	56986	*53360	53784	7464
42842	4281	44581	56986	*53230	53784	56986	7465
42843	42820	44589	*53100	53784	56986	*53511	7466
4289	42821	*4449	53784	56986	*53361	53784	7467
5184	42822	44501	56986	*53231	53784	56986	74681
*42832	42823	44502	*53101	53784	56986	*53521	74682
39891	42830	44581	53784	56986	*53370	53784	74683
40201	42831	44589	56986	*53240	53784	56986	74684
40211	42832	*44501	*53110	53784	56986	*53531	74686
40291	42833	44501	53784	56986	*53371	53784	74711
4280	42840	*44502	56986	*53241	53784	56986	74722
4281	42841	44502	*53111	53784	56986	*53541	*76520
42820	42842	*44581	53784	56986	*53390	53784	76501
42821	42843	44581	56986	*53250	53784	56986	76502
42822	4289	*44589	*53120	53784	56986	*53551	76503
42823	5184	44589	53784	56986	*53391	53784	76504
42830	*42842	*4560	56986	*53251	53784	56986	76505
42831	39891	53784	*53121	53784	56986	*53561	76506
42832	40201	56986	53784	56986	*53400	53784	76507
42833	40211	*45989	56986	*53260	53784	56986	76508
42840	40291	42820	*53130	53784	56986	*53783	*76521
42841	4280	42821	53784	56986	*53401	53784	76501
42842	4281	42822	56986	*53261	53784	56986	76502
42843	42820	42823	*53131	53784	56986	*53784	76503
4289	42821	42830	53784	56986	*53410	53784	76504

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

76505	76506	769	76508	7703	7713	78039	03811
76506	76507	7700	7670	7704	77181	7817	03819
76507	76508	7701	7685	7705	77183	7854	0382
76508	*7685	7702	769	7707	77210	78550	0383
*76522	77084	7703	7700	77084	77211	78551	03840
76501	*7686	7704	7701	7710	77212	78559	03841
76502	77084	7705	7702	7711	77213	7863	03842
76503	*7689	7707	7703	7713	77214	78820	03843
76504	77084	77084	7704	77181	7722	78829	03844
76505	*769	*7709	7705	77183	7724	7895	03849
76506	77084	77084	7707	77210	7725	7907	0388
76507	*7700	*7714	77084	77211	7730	7911	0389
76508	77084	77181	7710	77212	7731	7913	0545
*76523	*7701	77183	7711	77213	7732	7991	99590
76501	77084	*7715	7713	77214	7733	7994	99591
76502	*7702	77181	77181	7722	7734	*78099	99592
76503	77084	77183	77183	7724	7740	04082	99593
76504	*7703	*7716	77210	7725	7741	44024	99594
76505	77084	77181	77211	7730	7742	78001	*99592
76506	*7704	77183	77212	7731	77430	78003	0362
76507	77084	*7717	77213	7732	77431	7801	0380
76508	*7705	77181	77214	7733	77439	78031	03810
*76524	77084	77183	7722	7734	7744	78039	03811
76501	*7706	*77181	7724	7740	7745	7817	03819
76502	77084	77181	7725	7741	7747	7854	0382
76503	*7707	77183	7730	7742	7751	78550	0383
76504	77084	*77182	7731	77430	7752	78551	03840
76505	*77081	77181	7732	77431	7753	78559	03841
76506	7685	77183	7733	77439	7754	7863	03842
76507	769	*77183	7734	7744	7755	78820	03843
76508	7700	77181	7740	7745	7756	78829	03844
*76525	7701	77183	7741	7747	7757	7895	03849
76501	7702	*77189	7742	7751	7760	7907	0388
76502	7703	77181	77430	7752	7761	7911	0389
76503	7704	77183	77431	7753	7762	7913	0545
76504	7705	*7760	77439	7754	7763	7991	99590
76505	7707	77181	7744	7755	7771	7994	99591
76506	77084	77183	7745	7756	7772	*78550	99592
76507	*77082	*7761	7747	7757	7775	04082	99593
76508	7685	77181	7751	7760	7776	*78551	99594
*76526	769	77183	7752	7761	7780	04082	*99593
76501	7700	*7762	7753	7762	7790	*78559	0362
76502	7701	77181	7754	7763	7791	04082	0380
76503	7702	77183	7755	7771	7797	*7859	03810
76504	7703	*7763	7756	7772	*78091	04082	03811
76505	7704	77181	7757	7775	04082	*7998	03819
76506	7705	77183	7760	7776	44024	04082	0382
76507	7707	*7764	7761	7780	78001	*99590	0383
76508	77084	77181	7762	7790	78003	0362	03840
*76527	*77083	77183	7763	7791	7801	0380	03841
76501	7685	*7765	7771	7797	78031	03810	03842
76502	769	77181	7772	*77989	78039	03811	03843
76503	7700	77183	7775	76501	7817	03819	03844
76504	7701	*7766	7776	76502	7854	0382	03849
76505	7702	77181	7780	76503	78550	0383	0388
76506	7703	77183	7790	76504	78551	03840	0389
76507	7704	*7767	7791	76505	78559	03841	0545
76508	7705	77181	7797	76506	7863	03842	99590
*76528	7707	77183	*77982	76507	78820	03843	99591
76501	77084	*7768	76501	76508	78829	03844	99592
76502	*77084	77181	76502	7670	7895	03849	99593
76503	7685	77183	76503	7685	7907	0388	99594
76504	769	*7769	76504	769	7911	0389	*99594
76505	7700	77181	76505	7700	7913	0545	0362
76506	7701	77183	76506	7701	7991	99590	0380
76507	7702	*77981	76507	7702	7994	99591	03810
76508	7703	76501	76508	7703	*78092	99592	03811
*76529	7704	76502	7670	7704	04082	99593	03819
76501	7705	76503	7685	7705	44024	99594	0382
76502	7707	76504	769	7707	78001	*99591	0383
76503	77084	76505	7700	77084	78003	0362	03840
76504	*77089	76506	7701	7710	7801	0380	03841
76505	7685	76507	7702	7711	78031	03810	03842

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

03843	99591
03844	99592
03849	99593
0388	99594
0389	*V096
0545	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V0970
*99791	99590
99831	99591
99832	99592
*99799	99593
99831	99594
99832	*V0971
*99831	99590
99831	99591
99832	99592
*99832	99593
99831	99594
99832	*V0980
*99881	99590
99831	99591
99832	99592
*99883	99593
99831	99594
99832	*V0981
*99889	99590
99831	99591
99832	99592
*9989	99593
99831	99594
99832	*V0990
*V090	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V0991
*V091	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V2341
*V092	V237
99590	V2381
99591	V2382
99592	V2383
99593	V2384
99594	V2389
*V093	V239
99590	*V2349
99591	V237
99592	V2381
99593	V2382
99594	V2383
*V094	V2384
99590	V2389
99591	V239
99592	*V462
99593	V461
99594	
*V0950	
99590	
99591	
99592	
99593	
99594	
*V0951	
99590	

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are in Table 6H-Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*7708	7722	9983
7685	7724	*9989
769	7725	9983
7700	7730	*V234
7701	7731	V237
7702	7732	V2381
7703	7733	V2382
7704	7734	V2383
7705	7740	V2384
7707	7741	V2389
*7714	7742	V239
7718	77430	
*7715	77431	
7718	77439	
*7716	7744	
7718	7745	
*7717	7747	
7718	7751	
*7718	7752	
7718	7753	
*7760	7754	
7718	7755	
*7761	7756	
7718	7757	
*7762	7760	
7718	7761	
*7763	7762	
7718	7763	
*7764	7771	
7718	7772	
*7765	7775	
7718	7776	
*7766	7780	
7718	7790	
*7767	7791	
7718	7797	
*7768	*7809	
7718	44024	
*7769	78001	
7718	78003	
*7798	7801	
76501	78031	
76502	78039	
76503	7817	
76504	7854	
76505	78550	
76506	78551	
76507	78559	
76508	7863	
7670	78820	
7685	78829	
769	7895	
7700	7907	
7701	7911	
7702	7913	
7703	7991	
7704	7994	
7705	*99791	
7707	9983	
7710	*99799	
7711	9983	
7713	*9983	
7718	9983	
77210	*99881	
77211	9983	
77212	*99883	
77213	9983	
77214	*99889	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34667	8.9765	2	3	6	12	19
2	7122	9.9083	3	5	8	13	20
3	7	7.4286	1	1	3	4	10
4	6414	7.1743	1	2	5	9	16
5	93169	3.0674	1	1	2	3	7
6	398	2.9196	1	1	2	4	6
7	14187	9.7565	1	4	7	12	20
8	4350	2.7572	1	1	1	3	6
9	1738	6.4689	1	3	5	8	13
10	18019	6.5224	2	3	5	8	13
11	3400	4.0044	1	2	3	5	8
12	49655	5.8699	2	3	4	7	11
13	6646	5.0141	2	3	4	6	9
14	320358	5.8150	2	3	5	7	11
15	152285	3.4737	1	2	3	4	6
16	11455	6.0111	2	3	5	7	12
17	3729	3.2773	1	2	3	4	6
18	28016	5.4234	2	3	4	7	10
19	8679	3.5369	1	2	3	5	7
20	5618	10.4676	3	5	8	13	20
21	1429	6.5850	2	3	5	8	13
22	2723	5.0165	2	2	4	6	10
23	11192	4.2429	1	2	3	5	8
24	55364	4.8878	1	2	4	6	10
25	27208	3.2250	1	2	3	4	6
26	34	4.6765	1	1	2	4	6
27	3839	5.0253	1	1	3	6	11
28	12344	6.2286	1	3	5	8	13
29	4930	3.5613	1	2	3	5	7
31	3815	4.0765	1	2	3	5	8
32	1893	2.4464	1	1	2	3	5
34	21788	5.0453	1	2	4	6	9
35	6839	3.2388	1	1	3	4	6
36	2493	1.4705	1	1	1	1	2
37	1419	3.8182	1	1	2	4	9
38	93	2.4946	1	1	1	3	6
39	667	1.9340	1	1	1	2	4
40	1524	3.6037	1	1	2	5	8
42	1938	2.3710	1	1	1	3	5
43	110	3.0455	1	1	2	4	6
44	1295	5.0347	2	3	4	6	9
45	2600	3.2423	1	2	3	4	6
46	3374	4.5871	1	2	4	6	9
47	1350	3.1719	1	1	3	4	6
48	1	2.0000	2	2	2	2	2
49	2335	4.6188	1	2	3	5	9
50	2483	1.8212	1	1	1	2	3
51	251	3.1195	1	1	1	3	7
52	239	1.9205	1	1	1	2	3
53	2516	3.3792	1	1	2	4	8
54	1	4.0000	4	4	4	4	4
55	1566	3.0556	1	1	1	3	6
56	528	2.9848	1	1	2	3	6
57	692	3.6893	1	1	2	4	8
59	128	2.6641	1	1	1	3	6
60	6	3.3333	1	1	2	5	5
61	243	4.8354	1	1	3	7	10
62	3	1.6667	1	1	1	3	3
63	2887	4.4891	1	1	3	6	9
64	3132	6.6028	1	2	4	8	14
65	39024	2.7977	1	1	2	3	5
66	7671	3.1068	1	1	2	4	6
67	440	3.5955	1	2	3	4	6
68	8648	3.8274	1	2	3	5	7
69	2973	3.0054	1	2	2	4	6
70	25	3.4800	1	2	3	4	8
71	87	3.4368	1	2	3	4	6
72	926	3.5659	1	1	3	4	7
73	7073	4.3867	1	2	3	6	9
75	39878	10.0489	3	5	7	12	20

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
76	41691	11.4166	3	5	9	14	22
77	2445	4.8634	1	2	4	7	10
78	35316	6.6636	3	4	6	8	11
79	166404	8.5040	3	4	7	11	16
80	8320	5.4954	2	3	5	7	10
81	2	8.0000	3	3	13	13	13
82	63426	6.9938	2	3	6	9	14
83	6394	5.4759	2	3	4	7	10
84	1559	3.2290	1	2	3	4	6
85	21268	6.3168	2	3	5	8	12
86	2180	3.8138	1	2	3	5	8
87	59482	6.3070	1	3	5	8	12
88	396842	5.1059	2	3	4	6	9
89	502709	5.8920	2	3	5	7	11
90	46817	4.0322	2	2	3	5	7
91	57	4.0000	2	2	3	5	8
92	14816	6.3579	2	3	5	8	12
93	1710	4.1076	1	2	3	5	8
94	12574	6.3304	2	3	5	8	13
95	1679	3.7123	1	2	3	5	7
96	53729	4.5526	2	2	4	6	8
97	28601	3.5208	1	2	3	4	6
98	15	5.0000	1	2	3	4	13
99	21279	3.1677	1	1	2	4	6
100	8950	2.1349	1	1	2	3	4
101	21127	4.3832	1	2	3	6	9
102	5559	2.5690	1	1	2	3	5
103	428	49.2103	9	14	26	61	116
104	19836	14.4245	6	8	12	17	25
105	27462	9.9935	5	6	8	11	18
106	3308	11.3987	5	7	10	14	20
107	85791	10.4560	5	7	9	12	17
108	6205	10.2743	3	5	8	13	20
109	59572	7.7288	4	5	6	9	13
110	53172	9.0340	2	4	7	11	18
111	9394	4.4159	1	2	4	6	8
113	41424	12.4557	4	6	9	15	24
114	8852	8.5204	2	4	7	11	17
115	15271	8.2839	1	4	7	11	16
116	109277	4.4721	1	2	3	6	9
117	4177	4.1611	1	1	2	5	9
118	8112	2.8930	1	1	1	3	7
119	1316	5.1117	1	1	3	6	12
120	37220	8.7981	1	2	6	12	20
121	167308	6.3297	2	3	5	8	12
122	81710	3.6163	1	2	3	5	7
123	41163	4.7016	1	1	3	6	11
124	137232	4.3524	1	2	3	5	8
125	91133	2.7831	1	1	2	4	5
126	5016	11.8909	4	6	9	15	22
127	682134	5.2700	2	3	4	7	10
128	8254	5.4723	2	3	5	7	9
129	4105	2.8378	1	1	1	3	6
130	88700	5.6615	2	3	5	7	10
131	27798	4.0539	1	2	4	5	7
132	152312	2.9301	1	1	2	4	5
133	8929	2.2655	1	1	2	3	4
134	39623	3.1770	1	2	2	4	6
135	7554	4.4298	1	2	3	5	8
136	1237	2.5594	1	1	2	3	5
138	203378	3.9834	1	2	3	5	8
139	90000	2.4829	1	1	2	3	5
140	66435	2.5585	1	1	2	3	5
141	102391	3.5917	1	2	3	4	7
142	51719	2.5539	1	1	2	3	5
143	250133	2.0827	1	1	2	3	4
144	88510	5.4530	1	2	4	7	11
145	7598	2.6481	1	1	2	3	5
146	10799	10.2146	5	7	8	12	17
147	2798	6.4010	3	5	6	8	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
148	129350	12.2861	5	7	10	15	22
149	19313	6.4669	4	5	6	8	10
150	20328	11.2319	4	7	10	14	20
151	4963	5.6756	1	3	5	8	10
152	4425	8.3250	3	5	7	10	14
153	2014	5.3803	3	4	5	7	8
154	29001	13.2057	3	7	10	16	26
155	7262	3.9898	1	2	3	6	8
156	3	15.0000	11	11	13	21	21
157	8154	5.5581	1	2	4	7	11
158	4562	2.5184	1	1	2	3	5
159	17114	5.0598	1	2	4	6	10
160	12169	2.6492	1	1	2	3	5
161	11152	4.1588	1	1	3	5	9
162	7288	1.9175	1	1	1	2	4
163	3	3.0000	1	1	3	5	5
164	5118	8.2651	3	5	7	10	14
165	2185	4.6499	2	3	4	6	8
166	3903	4.8737	1	2	4	6	9
167	3800	2.5132	1	1	2	3	4
168	1279	5.0023	1	2	3	6	11
169	827	2.2866	1	1	2	3	5
170	12108	10.9853	2	4	8	14	22
171	1355	4.3107	1	2	3	6	9
172	30622	6.9624	2	3	5	9	14
173	2711	3.7444	1	1	3	5	8
174	247222	4.8059	2	3	4	6	9
175	35165	2.9201	1	2	3	4	5
176	15219	5.2481	2	3	4	6	10
177	9429	4.5038	2	2	4	6	8
178	3758	3.0780	1	2	3	4	6
179	12541	5.9632	2	3	5	7	11
180	88300	5.3709	2	3	4	7	10
181	27097	3.3767	1	2	3	4	6
182	248889	4.4042	1	2	3	5	8
183	87342	2.8973	1	1	2	4	5
184	90	2.9000	1	1	2	4	6
185	5021	4.7104	1	2	3	6	9
186	3	4.6667	2	2	3	9	9
187	446	4.3565	1	2	3	6	8
188	79403	5.5558	1	2	4	7	11
189	13113	3.0563	1	1	2	4	6
190	74	4.7838	1	2	3	5	9
191	9222	13.7304	3	6	10	17	28
192	1257	6.0963	1	3	5	8	11
193	4865	12.7394	5	7	10	16	23
194	733	6.8759	2	4	6	8	12
195	4157	10.3560	4	6	9	12	18
196	1051	5.4186	2	3	5	7	9
197	18569	8.9827	3	5	7	11	16
198	5672	4.4381	2	3	4	6	8
199	1644	9.9179	2	4	7	13	21
200	1042	10.4539	1	3	7	14	22
201	1466	14.4734	3	6	11	18	29
202	26156	6.3731	2	3	5	8	13
203	29310	6.7403	2	3	5	9	13
204	61544	5.8119	2	3	4	7	11
205	24459	6.1537	2	3	5	8	12
206	2049	3.9204	1	2	3	5	8
207	32107	5.1834	1	2	4	7	10
208	10745	2.8598	1	1	2	4	5
209	371105	4.9903	3	3	4	6	8
210	121541	6.8894	3	4	6	8	11
211	32567	4.9284	3	4	5	6	7
212	7	3.2857	1	2	2	2	4
213	9878	9.1432	2	4	7	11	18
216	6916	9.5448	2	4	7	12	19
217	17029	13.4060	3	5	9	16	28
218	22745	5.4427	2	3	4	7	10
219	20867	3.2086	1	2	3	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	1	2.0000	2	2	2	2	2
223	13667	2.8776	1	1	2	3	6
224	12467	1.8627	1	1	1	2	3
225	6124	5.0144	1	2	3	7	11
226	5702	6.6733	1	3	5	8	14
227	4923	2.6669	1	1	2	3	5
228	2481	4.0806	1	1	2	5	9
229	1176	2.2168	1	1	2	3	4
230	2407	5.0586	1	2	3	6	11
231	13540	4.8875	1	1	3	6	10
232	882	2.7426	1	1	1	3	7
233	7199	7.2148	1	3	5	9	15
234	4623	3.1573	1	1	2	4	7
235	5091	5.0304	1	2	4	6	9
236	39785	4.7450	1	3	4	6	9
237	1744	3.5740	1	2	3	4	7
238	8625	8.8420	3	4	7	11	17
239	48235	6.2846	2	3	5	8	12
240	11808	6.7199	2	3	5	8	13
241	3223	3.8849	1	2	3	5	7
242	2516	6.5568	2	3	5	8	13
243	93807	4.6804	1	2	4	6	9
244	13584	4.7331	1	2	4	6	9
245	5733	3.3630	1	2	3	4	6
246	1347	3.7647	1	2	3	5	7
247	19620	3.3687	1	1	3	4	6
248	12067	4.8652	1	2	4	6	9
249	12912	3.6678	1	1	2	4	8
250	3795	4.1686	1	2	3	5	7
251	2489	2.7814	1	1	2	4	5
253	20861	4.6779	1	3	4	6	9
254	10809	3.1314	1	2	3	4	6
255	1	2.0000	2	2	2	2	2
256	6422	5.1110	1	2	4	6	10
257	16706	2.6651	1	1	2	3	5
258	16972	1.8186	1	1	2	2	3
259	3813	2.6693	1	1	1	2	6
260	5087	1.3666	1	1	1	1	2
261	1889	2.1615	1	1	1	2	4
262	683	4.2958	1	1	3	5	10
263	24569	11.8050	3	5	8	14	23
264	3982	6.9006	2	3	5	8	14
265	4052	6.7347	1	2	4	8	14
266	2676	3.1371	1	1	2	4	6
267	267	4.2584	1	1	2	4	8
268	899	3.6274	1	1	2	4	8
269	9064	8.2177	2	3	6	10	17
270	2746	3.2618	1	1	2	4	7
271	19612	7.2767	2	4	6	9	13
272	5471	6.1349	2	3	5	7	12
273	1387	3.9250	1	2	3	5	7
274	2344	6.7675	1	3	5	8	14
275	247	3.0202	1	1	2	4	6
276	1315	4.5384	1	2	4	6	8
277	93957	5.7577	2	3	5	7	10
278	31764	4.2755	2	3	4	5	7
279	3	7.0000	3	3	8	10	10
280	17047	4.1686	1	2	3	5	8
281	7834	2.9183	1	1	2	4	5
283	5638	4.6568	1	2	4	6	9
284	1950	3.0569	1	1	2	4	6
285	6574	10.6492	3	5	8	13	20
286	2183	5.9464	2	3	4	7	11
287	6460	10.5718	3	5	8	12	20
288	3675	5.3897	2	3	4	6	8
289	6423	2.8026	1	1	1	3	6
290	9500	2.2281	1	1	1	2	4
291	78	1.6026	1	1	1	2	3
292	5423	9.9458	2	4	8	13	20
293	345	4.9246	1	2	3	7	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	95391	4.5356	1	2	3	6	9
295	3359	3.9690	1	2	3	5	7
296	250941	5.1144	1	2	4	6	10
297	47743	3.3559	1	2	3	4	6
298	103	4.3495	1	2	3	5	8
299	1218	5.3760	1	2	4	6	10
300	17546	6.1581	2	3	5	8	12
301	3644	3.6509	1	2	3	5	7
302	7896	8.6990	4	5	7	10	15
303	20694	8.2722	3	4	6	9	15
304	11944	8.6761	2	4	6	11	18
305	2972	3.5697	1	2	3	4	6
306	7213	5.4883	1	2	3	7	13
307	2168	2.2002	1	1	2	3	4
308	7359	6.3367	1	2	4	8	14
309	4375	2.1913	1	1	2	3	4
310	24597	4.3470	1	1	3	5	9
311	8323	1.8264	1	1	1	2	3
312	1547	4.4945	1	1	3	6	10
313	644	2.1289	1	1	1	2	4
314	1	5.0000	5	5	5	5	5
315	31230	6.8866	1	1	4	9	16
316	116645	6.6308	2	3	5	8	13
317	1890	3.0899	1	1	2	3	7
318	5739	6.0294	1	3	4	8	12
319	494	2.8543	1	1	2	4	6
320	193283	5.3020	2	3	4	7	10
321	30745	3.7500	1	2	3	5	7
322	64	3.6563	1	2	3	4	7
323	18622	3.1423	1	1	2	4	6
324	7455	1.8437	1	1	1	2	3
325	8938	3.7880	1	2	3	5	7
326	2803	2.6718	1	1	2	3	5
327	2	2.5000	1	1	4	4	4
328	685	3.7883	1	1	3	5	7
329	105	2.2000	1	1	1	2	5
331	49140	5.5819	1	3	4	7	11
332	5119	3.1686	1	1	2	4	6
333	311	4.6849	1	2	3	6	10
334	10271	4.7684	2	3	4	5	8
335	12383	3.1779	2	2	3	4	5
336	36334	3.4249	1	2	2	4	7
337	29524	2.0688	1	1	2	2	3
338	1055	5.5526	1	2	3	8	13
339	1505	4.6186	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3670	3.0695	1	1	2	3	6
342	723	3.1355	1	1	2	4	6
343	1	5.0000	5	5	5	5	5
344	3810	2.2850	1	1	1	2	4
345	1180	3.8542	1	1	2	4	8
346	4562	6.0342	1	3	5	8	12
347	373	2.6971	1	1	2	3	6
348	3281	4.1591	1	2	3	5	8
349	597	2.4623	1	1	2	3	5
350	6497	4.5045	2	2	4	6	8
351	1	1.0000	1	1	1	1	1
352	768	3.9557	1	2	3	5	8
353	2659	6.4772	2	3	5	7	12
354	7491	5.8265	3	3	4	7	10
355	5680	3.2347	2	2	3	4	5
356	25943	2.1725	1	1	2	3	4
357	5715	8.4126	3	4	6	10	16
358	20616	4.3038	2	3	3	5	7
359	31095	2.6372	1	2	3	3	4
360	15579	2.8185	1	2	2	3	5
361	369	3.6694	1	1	2	4	8
362	2	1.0000	1	1	1	1	1
363	2684	3.6256	1	2	2	4	7
364	1632	3.8762	1	1	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
365	1770	7.3989	1	3	5	9	16
366	4436	6.8537	2	3	5	9	14
367	521	3.0115	1	1	2	4	6
368	3288	6.7318	2	3	5	8	13
369	3280	3.1976	1	1	2	4	6
370	1244	5.6937	3	3	4	5	9
371	1416	3.6031	2	3	3	4	5
372	919	3.6529	1	2	2	3	5
373	3878	2.2935	1	2	2	3	3
374	116	2.8793	1	2	2	3	5
375	8	5.2500	1	3	5	5	9
376	263	3.5095	1	2	2	4	6
377	29	4.3793	1	2	3	4	7
378	169	2.4615	1	1	2	3	4
379	408	3.0000	1	1	2	3	6
380	76	1.9605	1	1	1	2	4
381	181	2.0829	1	1	1	2	4
382	25	1.3600	1	1	1	1	3
383	1841	3.9620	1	1	3	4	8
384	149	2.7315	1	1	1	3	6
389	5	3.4000	1	1	2	4	8
390	8	2.7500	1	1	1	4	5
392	2247	9.5167	2	4	7	12	19
393	1	2.0000	2	2	2	2	2
394	1959	6.2950	1	2	4	8	14
395	100668	4.3478	1	2	3	5	9
396	11	3.8182	1	1	2	4	6
397	17952	5.1683	1	2	4	7	10
398	17121	5.8897	2	3	5	7	11
399	1788	3.5520	1	2	3	5	7
400	6488	8.9578	1	3	6	11	20
401	5837	11.2479	2	5	9	15	23
402	1598	3.8899	1	1	3	5	8
403	32013	8.0033	2	3	6	10	17
404	4593	4.1916	1	2	3	5	9
406	2495	9.6970	2	4	7	12	20
407	702	4.1140	1	2	3	5	8
408	2122	7.8591	1	2	5	10	18
409	2517	6.1339	2	3	4	6	13
410	30770	4.0138	1	2	4	5	6
411	14	2.9286	1	1	2	4	6
412	18	2.0000	1	1	1	2	4
413	5767	7.2917	2	3	6	9	14
414	763	4.0170	1	2	3	5	8
415	39920	14.4391	4	6	11	18	29
416	181162	7.4625	2	4	6	9	14
417	37	6.1351	2	2	4	8	13
418	23410	6.1742	2	3	5	8	12
419	15730	4.6490	1	2	4	6	9
420	2958	3.4324	1	2	3	4	6
421	9274	3.7804	1	2	3	4	7
422	69	2.9130	1	1	2	3	6
423	7273	8.2391	2	3	6	10	17
424	1292	12.9690	2	5	9	16	26
425	16309	3.8956	1	2	3	5	8
426	4483	4.4716	1	2	3	5	9
427	1576	4.4143	1	2	3	5	9
428	745	7.3732	1	2	4	8	15
429	27035	6.1425	2	3	4	7	12
430	63072	7.9697	2	3	6	10	16
431	321	5.9470	1	2	4	7	13
432	411	4.5645	1	1	3	5	9
433	5523	2.9714	1	1	2	3	6
439	1457	8.5003	1	3	6	10	17
440	5440	9.0241	2	3	6	11	20
441	612	3.0735	1	1	2	4	7
442	16697	8.5604	1	3	6	10	18
443	3806	3.5365	1	1	3	4	7
444	5676	4.3175	1	2	3	5	8
445	2726	2.8995	1	1	2	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
447	6278	2.4462	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	30479	3.6797	1	1	3	4	8
450	7369	1.9900	1	1	1	2	4
451	5	1.6000	1	1	2	2	2
452	25229	5.0164	1	2	3	6	10
453	5648	2.7665	1	1	2	3	5
454	4624	4.3575	1	2	3	5	9
455	1098	2.3752	1	1	2	3	5
461	4563	4.0690	1	1	2	4	10
462	11994	11.3643	4	6	10	14	21
463	25215	4.1639	1	2	3	5	8
464	7115	3.0145	1	1	2	4	6
465	224	2.8973	1	1	1	3	5
466	1797	3.9321	1	1	2	4	7
467	1043	8.3931	1	1	2	3	6
468	57090	12.8803	3	6	10	16	25
471	12468	5.4931	3	3	4	6	9
473	8236	12.3409	1	3	7	17	32
475	104072	11.1941	2	5	9	15	22
476	3803	11.2611	2	5	10	15	21
477	25564	8.1456	1	3	6	11	17
478	108638	7.3817	1	3	5	9	16
479	24179	3.3012	1	1	3	4	7
480	622	21.5354	7	9	14	28	49
481	726	21.9353	13	17	20	25	33
482	5562	13.2251	4	7	10	16	25
483	43028	39.7169	15	22	33	49	71
484	317	13.0820	2	5	10	18	27
485	3029	9.4262	4	5	7	11	18
486	1867	12.3214	1	5	10	16	25
487	3536	7.6683	1	3	6	10	16
488	776	16.9162	3	6	13	22	35
489	13557	8.5376	2	3	6	10	18
490	5252	5.2582	1	2	4	6	10
491	13607	3.4664	1	2	3	4	6
492	2875	15.0104	2	5	7	25	34
493	58106	5.8777	1	3	5	7	11
494	30972	2.4751	1	1	2	3	5
495	211	17.1659	8	10	13	20	31
496	1842	9.4870	3	4	7	11	19
497	18414	6.5560	3	4	5	7	11
498	13584	4.1477	2	3	4	5	6
499	33300	4.6629	1	2	3	6	9
500	49827	2.4760	1	1	2	3	5
501	2356	10.6341	4	5	8	13	20
502	637	6.4066	2	4	5	8	11
503	5894	3.8884	1	2	3	5	7
504	123	34.9756	9	15	27	44	66
505	147	3.6667	1	1	1	5	9
506	937	17.2604	4	8	14	22	36
507	288	8.9549	2	4	7	12	18
508	667	8.2219	2	3	6	10	17
509	177	5.4350	1	2	4	7	10
510	1671	6.6092	1	3	5	8	13
511	616	4.3766	1	1	3	5	9
512	450	14.2244	6	8	11	15	24
513	142	10.7042	5	7	9	11	20
514	19261	7.2615	1	3	6	9	15
515	4570	5.4897	1	1	3	7	13
516	76256	4.7308	2	2	4	6	9
517	191586	2.6138	1	1	2	3	6
518	51638	3.3905	1	1	2	4	7
519	7316	5.1875	1	2	3	6	12
520	11118	2.1205	1	1	2	2	4
521	28568	5.7752	2	3	4	7	12
522	6141	9.4402	3	4	8	12	20
523	14812	4.0927	1	2	3	5	7
	11403341						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	27708	11.1212	3	5	8	14	22
2	14081	5.2277	1	3	4	7	10
3	7	7.4286	1	1	3	4	10
4	6426	7.1748	1	2	5	9	16
5	93169	3.0674	1	1	2	3	7
6	398	2.9196	1	1	2	4	6
7	14187	9.7565	1	4	7	12	20
8	4350	2.7572	1	1	1	3	6
9	1737	6.4669	1	3	5	8	13
10	18019	6.5224	2	3	5	8	13
11	3400	4.0044	1	2	3	5	8
12	49655	5.8699	2	3	4	7	11
13	6646	5.0141	2	3	4	6	9
14	236067	6.0768	2	3	5	7	12
15	101726	4.9503	2	3	4	6	9
16	9257	6.1391	2	3	5	8	12
17	2871	3.1379	1	1	2	4	6
18	28016	5.4234	2	3	4	7	10
19	8679	3.5369	1	2	3	5	7
20	5618	10.4676	3	5	8	13	20
21	1429	6.5850	2	3	5	8	13
22	2723	5.0165	2	2	4	6	10
23	11192	4.2429	1	2	3	5	8
24	55364	4.8878	1	2	4	6	10
25	27208	3.2250	1	2	3	4	6
26	34	4.6765	1	1	2	4	6
27	3839	5.0253	1	1	3	6	11
28	12344	6.2286	1	3	5	8	13
29	4930	3.5613	1	2	3	5	7
31	3815	4.0765	1	2	3	5	8
32	1893	2.4464	1	1	2	3	5
34	22342	5.0412	1	2	4	6	9
35	7331	3.2195	1	1	3	4	6
36	2493	1.4705	1	1	1	1	2
37	1419	3.8182	1	1	2	4	9
38	93	2.4946	1	1	1	3	6
39	667	1.9340	1	1	1	2	4
40	1524	3.6037	1	1	2	5	8
42	1938	2.3710	1	1	1	3	5
43	110	3.0455	1	1	2	4	6
44	1295	5.0347	2	3	4	6	9
45	2600	3.2423	1	2	3	4	6
46	3374	4.5871	1	2	4	6	9
47	1350	3.1719	1	1	3	4	6
48	1	2.0000	2	2	2	2	2
49	2337	4.6166	1	2	3	5	9
50	2483	1.8212	1	1	1	2	3
51	251	3.1195	1	1	1	3	7
52	239	1.9205	1	1	1	2	3
53	2518	3.3777	1	1	2	4	8
54	1	4.0000	4	4	4	4	4
55	1566	3.0556	1	1	1	3	6
56	528	2.9848	1	1	2	3	6
57	692	3.6893	1	1	2	4	8
59	128	2.6641	1	1	1	3	6
60	6	3.3333	1	1	2	5	5
61	243	4.8354	1	1	3	7	10
62	3	1.6667	1	1	1	3	3
63	2900	4.4831	1	1	3	6	9
64	3132	6.6028	1	2	4	8	14
65	39024	2.7977	1	1	2	3	5
66	7671	3.1068	1	1	2	4	6
67	440	3.5955	1	2	3	4	6
68	8754	3.8284	1	2	3	5	7
69	3035	2.9997	1	2	2	4	5
70	25	3.4800	1	2	3	4	8
71	87	3.4368	1	2	3	4	6
72	926	3.5659	1	1	3	4	7
73	7073	4.3867	1	2	3	6	9
75	39878	10.0489	3	5	7	12	20

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
76	41691	11.4166	3	5	9	14	22
77	2445	4.8634	1	2	4	7	10
78	35316	6.6636	3	4	6	8	11
79	166404	8.5040	3	4	7	11	16
80	8320	5.4954	2	3	5	7	10
81	2	8.0000	3	3	13	13	13
82	63426	6.9938	2	3	6	9	14
83	6394	5.4759	2	3	4	7	10
84	1559	3.2290	1	2	3	4	6
85	21268	6.3168	2	3	5	8	12
86	2180	3.8138	1	2	3	5	8
87	59482	6.3070	1	3	5	8	12
88	396842	5.1059	2	3	4	6	9
89	502709	5.8920	2	3	5	7	11
90	46817	4.0322	2	2	3	5	7
91	57	4.0000	2	2	3	5	8
92	14816	6.3579	2	3	5	8	12
93	1710	4.1076	1	2	3	5	8
94	12574	6.3304	2	3	5	8	13
95	1679	3.7123	1	2	3	5	7
96	53729	4.5526	2	2	4	6	8
97	28601	3.5208	1	2	3	4	6
98	15	5.0000	1	2	3	4	13
99	21279	3.1677	1	1	2	4	6
100	8950	2.1349	1	1	2	3	4
101	21127	4.3832	1	2	3	6	9
102	5559	2.5690	1	1	2	3	5
103	428	49.2103	9	14	26	61	116
104	19517	14.4041	6	8	12	17	25
105	27289	9.9529	5	6	8	11	18
106	3308	11.3987	5	7	10	14	20
107	85791	10.4560	5	7	9	12	17
108	6205	10.2743	3	5	8	13	20
109	59572	7.7288	4	5	6	9	13
110	53172	9.0340	2	4	7	11	18
111	9394	4.4159	1	2	4	6	8
113	41424	12.4557	4	6	9	15	24
114	8852	8.5204	2	4	7	11	17
115	15271	8.2839	1	4	7	11	16
116	109277	4.4721	1	2	3	6	9
117	4177	4.1611	1	1	2	5	9
118	8112	2.8930	1	1	1	3	7
119	1316	5.1117	1	1	3	6	12
120	37308	8.7872	1	2	6	12	20
121	167308	6.3297	2	3	5	8	12
122	81710	3.6163	1	2	3	5	7
123	41163	4.7016	1	1	3	6	11
124	138287	4.3673	1	2	3	6	8
125	90077	2.7417	1	1	2	4	5
126	5016	11.8909	4	6	9	15	22
127	682134	5.2700	2	3	4	7	10
128	8254	5.4723	2	3	5	7	9
129	4105	2.8378	1	1	1	3	6
130	88700	5.6615	2	3	5	7	10
131	27798	4.0539	1	2	4	5	7
132	152311	2.9301	1	1	2	4	5
133	8929	2.2655	1	1	2	3	4
134	39623	3.1770	1	2	2	4	6
135	7554	4.4298	1	2	3	5	8
136	1237	2.5594	1	1	2	3	5
138	203378	3.9834	1	2	3	5	8
139	90000	2.4829	1	1	2	3	5
140	66435	2.5585	1	1	2	3	5
141	102391	3.5917	1	2	3	4	7
142	51719	2.5539	1	1	2	3	5
143	250133	2.0827	1	1	2	3	4
144	88510	5.4530	1	2	4	7	11
145	7598	2.6481	1	1	2	3	5
146	10800	10.2147	5	7	8	12	17
147	2799	6.4012	3	5	6	8	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
148	129450	12.2855	5	7	10	15	22
149	19342	6.4670	4	5	6	8	10
150	20334	11.2329	4	7	10	14	20
151	4963	5.6756	1	3	5	8	10
152	4425	8.3250	3	5	7	10	14
153	2015	5.3782	3	4	5	7	8
154	29004	13.2062	3	7	10	16	26
155	7262	3.9898	1	2	3	6	8
156	3	15.0000	11	11	13	21	21
157	8155	5.5579	1	2	4	7	11
158	4564	2.5184	1	1	2	3	5
159	17115	5.0602	1	2	4	6	10
160	12172	2.6489	1	1	2	3	5
161	11155	4.1600	1	1	3	5	9
162	7290	1.9177	1	1	1	2	4
163	3	3.0000	1	1	3	5	5
164	5118	8.2651	3	5	7	10	14
165	2185	4.6499	2	3	4	6	8
166	3903	4.8737	1	2	4	6	9
167	3800	2.5132	1	1	2	3	4
168	1382	4.8705	1	2	3	6	10
169	869	2.2842	1	1	2	3	5
170	12156	10.9845	2	4	8	14	22
171	1359	4.3061	1	2	3	6	9
172	30622	6.9624	2	3	5	9	14
173	2711	3.7444	1	1	3	5	8
174	247222	4.8059	2	3	4	6	9
175	35165	2.9201	1	2	3	4	5
176	15219	5.2481	2	3	4	6	10
177	9429	4.5038	2	2	4	6	8
178	3758	3.0780	1	2	3	4	6
179	12541	5.9632	2	3	5	7	11
180	88300	5.3709	2	3	4	7	10
181	27097	3.3767	1	2	3	4	6
182	260686	4.3600	1	2	3	5	8
183	91243	2.8817	1	1	2	4	5
184	93	2.8387	1	1	2	4	6
185	5070	4.6984	1	2	3	6	9
186	3	4.6667	2	2	3	9	9
187	668	4.1153	1	2	3	6	8
188	79403	5.5558	1	2	4	7	11
189	13113	3.0563	1	1	2	4	6
190	74	4.7838	1	2	3	5	9
191	9222	13.7304	3	6	10	17	28
192	1257	6.0963	1	3	5	8	11
193	4865	12.7394	5	7	10	16	23
194	733	6.8759	2	4	6	8	12
195	4157	10.3560	4	6	9	12	18
196	1051	5.4186	2	3	5	7	9
197	18569	8.9827	3	5	7	11	16
198	5672	4.4381	2	3	4	6	8
199	1644	9.9179	2	4	7	13	21
200	1042	10.4539	1	3	7	14	22
201	2013	14.4287	4	6	11	18	28
202	26156	6.3731	2	3	5	8	13
203	29310	6.7403	2	3	5	9	13
204	61544	5.8119	2	3	4	7	11
205	24459	6.1537	2	3	5	8	12
206	2049	3.9204	1	2	3	5	8
207	32107	5.1834	1	2	4	7	10
208	10745	2.8598	1	1	2	4	5
209	371105	4.9903	3	3	4	6	8
210	121541	6.8894	3	4	6	8	11
211	32567	4.9284	3	4	5	6	7
212	7	3.2857	1	2	2	2	4
213	9878	9.1432	2	4	7	11	18
216	6916	9.5448	2	4	7	12	19
217	17029	13.4060	3	5	9	16	28
218	22744	5.4422	2	3	4	7	10
219	20866	3.2085	1	2	3	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	1	2.0000	2	2	2	2	2
223	13666	2.8724	1	1	2	3	6
224	12467	1.8627	1	1	1	2	3
225	6124	5.0144	1	2	3	7	11
226	5699	6.6699	1	3	5	8	14
227	4921	2.6651	1	1	2	3	5
228	2481	4.0806	1	1	2	5	9
229	1175	2.2179	1	1	2	3	4
230	2406	5.0590	1	2	3	6	11
231	12533	4.8810	1	1	3	6	11
232	882	2.7426	1	1	1	3	7
233	7179	7.2117	1	3	5	9	15
234	4607	3.1532	1	1	2	4	7
235	5091	5.0304	1	2	4	6	9
236	39785	4.7450	1	3	4	6	9
237	1744	3.5740	1	2	3	4	7
238	8625	8.8420	3	4	7	11	17
239	48230	6.2846	2	3	5	8	12
240	11807	6.7199	2	3	5	8	13
241	3223	3.8849	1	2	3	5	7
242	2516	6.5568	2	3	5	8	13
243	93654	4.6808	1	2	4	6	9
244	13584	4.7331	1	2	4	6	9
245	5732	3.3627	1	2	3	4	6
246	1346	3.7645	1	2	3	5	7
247	19620	3.3687	1	1	3	4	6
248	12067	4.8652	1	2	4	6	9
249	12651	3.6505	1	1	2	4	7
250	3795	4.1686	1	2	3	5	7
251	2489	2.7814	1	1	2	4	5
253	20861	4.6779	1	3	4	6	9
254	10809	3.1314	1	2	3	4	6
255	1	2.0000	2	2	2	2	2
256	6404	5.1084	1	2	4	6	10
257	16706	2.6651	1	1	2	3	5
258	16974	1.8185	1	1	2	2	3
259	3813	2.6693	1	1	1	2	6
260	5087	1.3666	1	1	1	1	2
261	1893	2.1590	1	1	1	2	4
262	686	4.2886	1	1	3	5	10
263	24569	11.8050	3	5	8	14	23
264	3982	6.9006	2	3	5	8	14
265	4052	6.7347	1	2	4	8	14
266	2676	3.1371	1	1	2	4	6
267	267	4.2584	1	1	2	4	8
268	899	3.6274	1	1	2	4	8
269	9064	8.2177	2	3	6	10	17
270	2746	3.2618	1	1	2	4	7
271	19612	7.2767	2	4	6	9	13
272	5471	6.1349	2	3	5	7	12
273	1387	3.9250	1	2	3	5	7
274	2344	6.7675	1	3	5	8	14
275	247	3.0202	1	1	2	4	6
276	1326	4.5181	1	2	4	6	8
277	93957	5.7577	2	3	5	7	10
278	31764	4.2755	2	3	4	5	7
279	3	7.0000	3	3	8	10	10
280	17047	4.1686	1	2	3	5	8
281	7834	2.9183	1	1	2	4	5
283	5638	4.6568	1	2	4	6	9
284	1950	3.0569	1	1	2	4	6
285	6574	10.6492	3	5	8	13	20
286	2183	5.9464	2	3	4	7	11
287	6460	10.5718	3	5	8	12	20
288	3675	5.3897	2	3	4	6	8
289	6423	2.8026	1	1	1	3	6
290	9500	2.2281	1	1	1	2	4
291	78	1.6026	1	1	1	2	3
292	5423	9.9458	2	4	8	13	20
293	345	4.9246	1	2	3	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	95391	4.5356	1	2	3	6	9
295	3359	3.9690	1	2	3	5	7
296	250941	5.1144	1	2	4	6	10
297	47743	3.3559	1	2	3	4	6
298	103	4.3495	1	2	3	5	8
299	1218	5.3760	1	2	4	6	10
300	17546	6.1581	2	3	5	8	12
301	3643	3.6508	1	2	3	5	7
302	7896	8.6990	4	5	7	10	15
303	20709	8.2736	3	4	6	9	15
304	12044	8.6857	2	4	6	11	18
305	3008	3.6051	1	2	3	5	6
306	7213	5.4883	1	2	3	7	13
307	2168	2.2002	1	1	2	3	4
308	7245	6.2803	1	2	4	8	14
309	4338	2.1547	1	1	2	3	4
310	24597	4.3470	1	1	3	5	9
311	8323	1.8264	1	1	1	2	3
312	1547	4.4945	1	1	3	6	10
313	644	2.1289	1	1	1	2	4
314	1	5.0000	5	5	5	5	5
315	33711	7.1835	1	1	4	9	17
316	115329	6.5892	2	3	5	8	13
317	1890	3.0899	1	1	2	3	7
318	5739	6.0294	1	3	4	8	12
319	494	2.8543	1	1	2	4	6
320	193283	5.3020	2	3	4	7	10
321	30745	3.7500	1	2	3	5	7
322	64	3.6563	1	2	3	4	7
323	18622	3.1423	1	1	2	4	6
324	7455	1.8437	1	1	1	2	3
325	8938	3.7880	1	2	3	5	7
326	2803	2.6718	1	1	2	3	5
327	2	2.5000	1	1	4	4	4
328	685	3.7883	1	1	3	5	7
329	105	2.2000	1	1	1	2	5
331	49140	5.5819	1	3	4	7	11
332	5119	3.1686	1	1	2	4	6
333	311	4.6849	1	2	3	6	10
334	10271	4.7684	2	3	4	5	8
335	12383	3.1779	2	2	3	4	5
336	36334	3.4249	1	2	2	4	7
337	29524	2.0688	1	1	2	2	3
338	1055	5.5526	1	2	3	8	13
339	1505	4.6186	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3670	3.0695	1	1	2	3	6
342	723	3.1355	1	1	2	4	6
343	1	5.0000	5	5	5	5	5
344	3840	2.3802	1	1	1	2	5
345	1336	4.7859	1	1	3	6	10
346	4562	6.0342	1	3	5	8	12
347	373	2.6971	1	1	2	3	6
348	3281	4.1591	1	2	3	5	8
349	597	2.4623	1	1	2	3	5
350	6497	4.5045	2	2	4	6	8
351	1	1.0000	1	1	1	1	1
352	768	3.9557	1	2	3	5	8
353	2659	6.4772	2	3	5	7	12
354	7491	5.8265	3	3	4	7	10
355	5680	3.2347	2	2	3	4	5
356	25943	2.1725	1	1	2	3	4
357	5715	8.4126	3	4	6	10	16
358	20617	4.3038	2	3	3	5	7
359	31095	2.6372	1	2	3	3	4
360	15583	2.8183	1	2	2	3	5
361	369	3.6694	1	1	2	4	8
362	2	1.0000	1	1	1	1	1
363	2683	3.6254	1	2	2	4	7
364	1631	3.8780	1	1	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
365	1834	7.6930	2	3	5	10	17
366	4436	6.8537	2	3	5	9	14
367	521	3.0115	1	1	2	4	6
368	3288	6.7318	2	3	5	8	13
369	3281	3.1987	1	1	2	4	6
370	1244	5.6937	3	3	4	5	9
371	1416	3.6031	2	3	3	4	5
372	919	3.6529	1	2	2	3	5
373	3878	2.2935	1	2	2	3	3
374	116	2.8793	1	2	2	3	5
375	8	5.2500	1	3	5	5	9
376	263	3.5095	1	2	2	4	6
377	29	4.3793	1	2	3	4	7
378	169	2.4615	1	1	2	3	4
379	408	3.0000	1	1	2	3	6
380	76	1.9605	1	1	1	2	4
381	181	2.0829	1	1	1	2	4
382	25	1.3600	1	1	1	1	3
383	1841	3.9620	1	1	3	4	8
384	149	2.7315	1	1	1	3	6
389	5	3.4000	1	1	2	4	8
390	1	4.0000	4	4	4	4	4
392	2247	9.5167	2	4	7	12	19
393	1	2.0000	2	2	2	2	2
394	2329	7.0575	1	2	5	9	15
395	100668	4.3478	1	2	3	5	9
396	11	3.8182	1	1	2	4	6
397	17952	5.1683	1	2	4	7	10
398	17121	5.8897	2	3	5	7	11
399	1788	3.5520	1	2	3	5	7
400	6488	8.9578	1	3	6	11	20
401	5837	11.2479	2	5	9	15	23
402	1599	3.8899	1	1	3	5	8
403	32013	8.0033	2	3	6	10	17
404	4592	4.1916	1	2	3	5	9
406	2495	9.6970	2	4	7	12	20
407	702	4.1140	1	2	3	5	8
408	2122	7.8591	1	2	5	10	18
409	2517	6.1339	2	3	4	6	13
410	30770	4.0138	1	2	4	5	6
411	14	2.9286	1	1	2	4	6
412	18	2.0000	1	1	1	2	4
413	5767	7.2917	2	3	6	9	14
414	763	4.0170	1	2	3	5	8
415	39922	14.4392	4	6	11	18	29
416	181162	7.4625	2	4	6	9	14
417	37	6.1351	2	2	4	8	13
418	23408	6.1732	2	3	5	8	12
419	15730	4.6490	1	2	4	6	9
420	2958	3.4324	1	2	3	4	6
421	9274	3.7804	1	2	3	4	7
422	69	2.9130	1	1	2	3	6
423	7273	8.2391	2	3	6	10	17
424	1292	12.9690	2	5	9	16	26
425	16309	3.8956	1	2	3	5	8
426	4483	4.4716	1	2	3	5	9
427	1576	4.4143	1	2	3	5	9
428	745	7.3732	1	2	4	8	15
429	27035	6.1425	2	3	4	7	12
430	63072	7.9697	2	3	6	10	16
431	321	5.9470	1	2	4	7	13
432	411	4.5645	1	1	3	5	9
433	5523	2.9714	1	1	2	3	6
439	1457	8.5003	1	3	6	10	17
440	5440	9.0241	2	3	6	11	20
441	612	3.0735	1	1	2	4	7
442	16700	8.5598	1	3	6	10	18
443	3808	3.5355	1	1	3	4	7
444	5676	4.3175	1	2	3	5	8
445	2726	2.8995	1	1	2	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
447	6278	2.4462	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	30478	3.6796	1	1	3	4	8
450	7369	1.9900	1	1	1	2	4
451	5	1.6000	1	1	2	2	2
452	25229	5.0164	1	2	3	6	10
453	5646	2.7669	1	1	2	3	5
454	4624	4.3575	1	2	3	5	9
455	1098	2.3752	1	1	2	3	5
461	4563	4.0690	1	1	2	4	10
462	11994	11.3643	4	6	10	14	21
463	25215	4.1639	1	2	3	5	8
464	7115	3.0145	1	1	2	4	6
465	224	2.8973	1	1	1	3	5
466	1797	3.9321	1	1	2	4	7
467	1043	8.3931	1	1	2	3	6
468	54726	12.9153	3	6	10	16	25
471	12468	5.4931	3	3	4	6	9
473	8236	12.3409	1	3	7	17	32
475	104072	11.1941	2	5	9	15	22
476	3814	11.2651	2	5	10	15	21
477	25602	8.1413	1	3	6	11	17
478	108638	7.3817	1	3	5	9	16
479	24179	3.3012	1	1	3	4	7
480	622	21.5354	7	9	14	28	49
481	726	21.9353	13	17	20	25	33
482	5300	12.4930	4	7	9	15	23
483	43301	39.6393	14	22	33	49	71
484	317	13.0820	2	5	10	18	27
485	3029	9.4262	4	5	7	11	18
486	1867	12.3214	1	5	10	16	25
487	3536	7.6683	1	3	6	10	16
488	776	16.9162	3	6	13	22	35
489	13557	8.5376	2	3	6	10	18
490	5252	5.2582	1	2	4	6	10
491	13607	3.4664	1	2	3	4	6
492	2875	15.0104	2	5	7	25	34
493	58106	5.8777	1	3	5	7	11
494	30972	2.4751	1	1	2	3	5
495	211	17.1659	8	10	13	20	31
496	1842	9.4870	3	4	7	11	19
497	19927	6.5368	3	4	5	7	11
498	14665	4.1305	2	3	4	5	6
499	32668	4.6299	1	2	3	6	9
500	49512	2.4657	1	1	2	3	5
501	2356	10.6341	4	5	8	13	20
502	637	6.4066	2	4	5	8	11
503	5894	3.8884	1	2	3	5	7
504	123	34.9756	9	15	27	44	66
505	147	3.6667	1	1	1	5	9
506	937	17.2604	4	8	14	22	36
507	288	8.9549	2	4	7	12	18
508	667	8.2219	2	3	6	10	17
509	177	5.4350	1	2	4	7	10
510	1671	6.6092	1	3	5	8	13
511	616	4.3766	1	1	3	5	9
512	450	14.2244	6	8	11	15	24
513	142	10.7042	5	7	9	11	20
514	19261	7.2615	1	3	6	9	15
515	4570	5.4897	1	1	3	7	13
516	76256	4.7308	2	2	4	6	9
517	191586	2.6138	1	1	2	3	6
518	51638	3.3905	1	1	2	4	7
519	7220	5.1497	1	2	3	6	12
520	11073	2.1137	1	1	2	2	4
521	28568	5.7752	2	3	4	7	12
522	6141	9.4402	3	4	8	12	20
523	14812	4.0927	1	2	3	5	7
524	136857	3.3964	1	2	3	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY 2001 MEDPAR Update 12/01 Grouper V20.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
525	492	15.9309	2	5	9	18	35
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2002

State	Urban	Rural
ALABAMA	0.337	0.394
ALASKA	0.407	0.675
ARIZONA	0.349	0.478
ARKANSAS	0.456	0.438
CALIFORNIA	0.335	0.419
COLORADO	0.463	0.538
CONNECTICUT	0.494	0.509
DELAWARE	0.516	0.484
DISTRICT OF COLUMBIA	0.413	.....
FLORIDA	0.349	0.365
GEORGIA	0.446	0.456
HAWAII	0.403	0.519
IDAHO	0.558	0.599
ILLINOIS	0.398	0.492
INDIANA	0.522	0.529
IOWA	0.484	0.594
KANSAS	0.380	0.591
KENTUCKY	0.478	0.490
LOUISIANA	0.390	0.482
MAINE	0.585	0.523
MARYLAND	0.759	0.821
MASSACHUSETTS	0.550	0.568
MICHIGAN	0.460	0.562
MINNESOTA	0.470	0.581
MISSISSIPPI	0.444	0.434
MISSOURI	0.399	0.473
MONTANA	0.504	0.544
NEBRASKA	0.428	0.550
NEVADA	0.284	0.473
NEW HAMPSHIRE	0.524	0.579
NEW JERSEY	0.393	.....
NEW MEXICO	0.471	0.516
NEW YORK	0.500	0.595
NORTH CAROLINA	0.511	0.465
NORTH DAKOTA	0.611	0.611
OHIO	0.492	0.568
OKLAHOMA	0.405	0.485
OREGON	0.545	0.579

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2002—Continued

State	Urban	Rural
PENNSYLVANIA	0.376	0.500
PUERTO RICO	0.467	0.561
RHODE ISLAND	0.486	.....
SOUTH CAROLINA	0.438	0.455
SOUTH DAKOTA	0.498	0.546
TENNESSEE	0.432	0.457
TEXAS	0.380	0.484
UTAH	0.495	0.570
VERMONT	0.572	0.595
VIRGINIA	0.452	0.546
WASHINGTON	0.580	0.598
WEST VIRGINIA	0.563	0.534
WISCONSIN	0.524	0.599
WYOMING	0.524	0.707

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2002

State	Ratio
ALABAMA	0.041
ALASKA	0.053
ARIZONA	0.038
ARKANSAS	0.049
CALIFORNIA	0.033
COLORADO	0.045
CONNECTICUT	0.036
DELAWARE	0.048
DISTRICT OF COLUMBIA	0.032
FLORIDA	0.043
GEORGIA	0.049
HAWAII	0.038
IDAHO	0.048
ILLINOIS	0.039
INDIANA	0.056

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2002—Continued

State	Ratio
IOWA	0.049
KANSAS	0.047
KENTUCKY	0.046
LOUISIANA	0.046
MAINE	0.038
MARYLAND	0.013
MASSACHUSETTS	0.050
MICHIGAN	0.044
MINNESOTA	0.043
MISSISSIPPI	0.043
MISSOURI	0.043
MONTANA	0.051
NEBRASKA	0.047
NEVADA	0.032
NEW HAMPSHIRE	0.058
NEW JERSEY	0.035
NEW MEXICO	0.045
NEW YORK	0.049
NORTH CAROLINA	0.047
NORTH DAKOTA	0.073
OHIO	0.047
OKLAHOMA	0.045
OREGON	0.042
PENNSYLVANIA	0.037
PUERTO RICO	0.041
RHODE ISLAND	0.031
SOUTH CAROLINA	0.046
SOUTH DAKOTA	0.050
TENNESSEE	0.049
TEXAS	0.043
UTAH	0.045
VERMONT	0.049
VIRGINIA	0.057
WASHINGTON	0.068
WEST VIRGINIA	0.044
WISCONSIN	0.050
WYOMING	0.062

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010005	01	3440	3440
010008	01	5240	.....
010010	01	3440	3440
010012	01	2880	.....
010022	01	2880	.....
010029	0580	1800	.....
010035	01	1000	.....
010036	01	2750	.....
010043	01	1000	1000
010044	01	25	.....
010072	01	0450	0450
010101	01	0450	0450

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010118	01	5240	
010120	01	5160	
010121	01	5240	
010126	01	2180	
010150	01	5240	
010158	01	2650	
020008	02	0380	
030007	03	2620	
030012	03	6200	
030033	03	2620	
030043	03	8520	
040014	04	4400	
040017	04	7920	
040019	04	4920	
040020	3700	4920	
040026	04	4400	
040027	04	7920	
040041	04	4400	
040045	04	26	
040066	04	4400	
040069	04	4920	
040076	04	4400	
040078	04	4400	
040080	04	3700	
040088	04	7680	
040091	04	8360	
040107	04	8360	
040119	04	4400	
050042	05	6690	
050045	05		7320
050069	5945	4480	
050071	7400	5775	
050073	8720	5775	
050076	7360	5775	
050101	8720	5775	
050150	05	6920	
050174	7500	8720	
050192	2840	05	
050228	7360	5775	
050230	5945	4480	
050236	8735	4480	
050286	8780	05	
050296	05	7120	
050301	05	7500	
050325	05	5170	
050335	05	5170	
050419	05	6690	
050446	0680	05	
050457	7360	5775	
050464	5170	8120	
050469	6780	05	
050494	05	6920	
050510	7360	5775	
050528	4940	05	
050541	7360	5775	
050549	8735	4480	
050569	05	7500	
050594	5945	4480	
050609	5945	4480	
050686	6780	5945	
050701	6780	7320	
060003	1125	2080	2080
060013	06	0200	
060018	06	2995	
060023	2995	6520	
060027	1125	2080	2080
060044	06	2080	
060049	06	2670	
060075	06	2995	
060076	06	3060	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
060096	06	2080	
060103	1125	2080	2080
070006	5483	5600	
070018	5483	5600	
070033	5483	5600	
070034	5483	5600	
070036	3283	5483	
080002	08		0720
080004	2190	9160	
080006	08	2190	
080007	08	2190	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020	5960	
100048	6080	10	
100049	10	3980	
100098	10	8960	8960
100103	10	3600	3600
100105	10	2710	
100109	10	5960	
100118	2020	10	
100150	10	5000	
100157	3980	8280	
100176	8960	2710	
100211	8280	3980	
100217	10	2710	
100232	10	5790	2900
100239	8280	7510	
100249	10	8280	
100268	8960	2680	
110001	11	0520	
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11	3600	
110029	11	0520	
110038	11	10	
110040	11	0500	0500
110050	11	0520	
110054	11	0520	
110075	11	7520	
110100	11	0600	
110118	11	0120	
110122	11	10	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110188	11	0520	
110189	11	0520	
110190	11	4680	
110205	11	0520	
120015	12	3320	
130002	13	29	
130003	13	50	
130011	13	50	
130018	13	6340	
130049	13	7840	
130060	13	1080	
140012	14	1600	
140015	14	7040	
140031	14	1400	
140032	14	7040	
140034	14	7040	
140040	14	6120	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	6120	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
140086	14	.....	7040
140093	14	1400	.....
140102	14	7880	7880
140110	14	6120	.....
140141	14	7040	7040
140143	14	6120	.....
140155	3740	.....	1600
140160	14	6880	.....
140161	14	1600	.....
140164	14	7040	.....
140189	14	1400	.....
140199	14	7040	.....
140230	14	.....	1400
140234	14	6120	.....
140245	14	.....	7040
140271	14	7800	7800
150002	2960	1600	.....
150004	2960	1600	.....
150006	15	7800	.....
150008	2960	1600	.....
150011	15	3480	3480
150015	15	1600	.....
150027	15	.....	3480
150030	15	3480	3480
150034	2960	1600	.....
150036	15	3850	.....
150048	15	2000	.....
150051	1020	.....	3480
150062	15	3480	3480
150065	15	3480	.....
150067	15	.....	3480
150069	15	1640	1640
150076	15	7800	.....
150090	2960	1600	.....
150096	15	2330	.....
150105	15	3480	3480
150112	15	3480	3480
150122	15	3480	.....
150125	2960	1600	1600
150126	2960	1600	1600
150132	2960	1600	.....
150133	15	2330	.....
150146	15	2330	.....
160001	16	2120	.....
160016	16	2120	.....
160026	16	2120	.....
160030	16	2120	.....
160037	16	24	.....
160057	16	3500	.....
160064	16	8920	.....
160080	16	1960	.....
160089	16	2120	.....
160094	16	8920	.....
160122	16	14	.....
160147	16	2120	.....
170001	17	9040	.....
170006	17	3710	.....
170010	17	8560	.....
170012	17	9040	.....
170013	17	9040	.....
170014	17	3760	.....
170020	17	9040	.....
170022	17	7000	.....
170023	17	9040	.....
170025	17	9040	.....
170033	17	9040	.....
170058	17	26	.....
170060	17	28	.....
170094	17	8440	.....
170120	17	3710	.....

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
170131	17	.....	8440
170137	4150	17	.....
170142	17	8440	.....
170145	17	8560	.....
170166	17	0320	.....
170175	17	9040	.....
180005	18	3400	.....
180011	18	4280	.....
180012	18	4520	.....
180013	18	5360	.....
180016	18	4520	.....
180018	18	4280	.....
180027	18	1660	.....
180028	18	3400	.....
180029	18	3660	.....
180044	18	3400	.....
180048	18	4280	.....
180054	18	1660	.....
180065	18	1640	.....
180066	18	5360	.....
180069	18	3400	.....
180078	18	3400	.....
180102	18	1660	.....
180104	18	1660	.....
180116	18	1660	.....
180124	18	5360	.....
180127	18	4520	.....
180132	18	4280	.....
180139	18	4280	.....
190001	19	5560	5560
190003	19	3880	.....
190010	19	5560	5560
190014	19	3880	.....
190015	19	5560	.....
190018	19	3880	.....
190025	19	3880	.....
190048	3350	19	.....
190054	19	3880	.....
190083	19	5200	.....
190086	19	5200	.....
190099	19	3880	.....
190106	19	3880	.....
190110	3880	19	.....
190131	19	5560	.....
190218	19	0220	.....
200020	6403	1123	1123
200024	4243	6403	.....
200034	4243	6403	.....
200039	20	6403	.....
200040	6403	.....	1123
200063	20	6403	.....
220060	1123	0743	.....
220077	8003	3283	.....
230015	23	3720	.....
230022	23	3720	.....
230027	23	3000	3000
230030	23	6960	.....
230036	23	6960	.....
230037	23	0440	.....
230040	23	3720	3720
230054	23	3080	.....
230078	0870	23	.....
230080	23	6960	.....
230093	23	3000	.....
230096	23	3720	.....
230097	23	3000	.....
230105	23	6960	.....
230106	23	3000	.....
230121	23	2640	2640
230188	23	6960	6960

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
230199	23	0870	0870
230235	23	6960	6960
230253	23	2160	
240008	24	6820	
240011	24	5120	
240014	24	5120	
240016	24	2520	
240018	24		5120
240023	24	5120	
240045	24	2240	
240064	24	2240	
240075	24	6980	
240088	24	6980	
240089	24	5120	
240100	24	2985	
240121	24	2240	
240139	24	5120	
240142	24	6980	
240152	24	5120	
250004	25	4920	
250009	25	3580	
250012	25	4920	
250025	25	1	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250058	25	3285	
250069	25	3560	
250078	3285	0920	
250079	25	3560	
250081	25	3560	
250082	25	6240	
250084	25	19	
250088	25	0760	
250094	3285	0920	
250097	25	0760	
250100	25	8600	
250101	25	3560	
250104	25	3560	
250122	25	19	
250126	25	4920	
260006	7000	26	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	14	
260034	26	3760	
260047	26	1740	
260050	26	7000	
260064	26	1740	
260074	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	7040
260113	26	14	
260116	26	7040	
260119	26	3700	
260120	26	3700	
260127	26	7040	
260131	26	1740	
260183	26	7040	
260186	26	1740	
270002	27	0880	
270003	27	3040	
270011	27	3040	
270016	27	0880	
270017	27	5140	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
270051	27	5140	
270057	27	0880	
270083	27	5140	
280009	28	4360	
280023	28	4360	
280032	28	4360	
280054	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280111	28	5920	
280125	28	7720	
290006	29	6720	
290019	29	6720	
300003	30	1123	
300005	30	1123	1123
300009	1123	30	
300019	30	22	
300024	30		1123
310001	0875	5600	
310002	5640	5600	
310003	3640	5600	
310015	5640	0875	
310021	8480	5190	
310031	6160	5190	
310038	5015	5600	
310039	5015	5190	
310045	0875	5600	
310048	5015	5640	
310049	3640		5640
310070	5015	5640	
310076	5640	5600	
310087	8760	6160	
310108	5015	5190	
310118	3640		0875
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320011	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330001	5660	5600	
330004	33	5660	
330023	2281	5660	
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330103	33		1280
330106	5380	5600	
330126	5660	5600	
330135	5660	5600	
330136	33	8160	
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330205	5660	5600	
330209	5660	5600	
330224	33	3283	
330235	8160		6840
330239	3610	2360	
330250	33	1303	
330264	5660	5600	
330307	33	8160	
330386	33	5660	
340003	34	3120	
340008	34	2560	
340013	34	1520	
340017	34	0480	
340021	34	1520	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
340023	34	0480	
340027	34	3150	
340039	34	1520	1520
340050	34	2560	
340051	34	3290	
340052	3120	1520	
340064	34	3120	
340068	34	9200	
340071	34	6640	6640
340084	34	1520	
340088	34	0480	
340097	34	3120	
340109	34	5720	5720
340115	34	6640	
340124	34	6640	6640
340126	34	6640	6640
340129	34	1520	
340131	34	3150	
340143	3290	1520	
340144	34	1520	
340147	6895	6640	
350005	35	2985	
350006	35	1010	
350009	35	2520	
350017	35	27	
350043	35	1010	
360002	36		1680
360008	36	3400	
360010	36	0080	
360011	36	1840	
360013	36	2000	
360014	36	1840	
360024	36	1680	1680
360025	36	1680	1680
360036	36	0080	
360037	1680	0080	
360039	36	1840	
360046	3200	1640	1640
360056	3200	1640	1640
360063	36	1680	1680
360065	36	1680	1680
360071	36	4320	4320
360076	3200	1640	1640
360078	0080		1680
360084	1320	0080	
360088	36	1840	
360089	36	8400	
360090	8400		2160
360092	36	1840	1840
360095	36	8400	
360101	1680	0080	
360107	36	8400	
360108	36	4800	
360109	36	1840	
360112	8400	0440	
360121	36	0440	
360132	3200	1640	1640
360142	36		1640
360144	1680	0080	
360159	36	1840	
360175	36	1840	1640
360197	36	1840	1840
360211	8080		6280
370004	37	3710	
370006	37	8560	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370022	37	4200	
370023	37	4200	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	
380002	38	4890	
380003	38	2400	
380006	38		6440
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380084	7080	38	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	
390016	39	6280	6280
390017	39	6280	6280
390030	39	0240	6680
390031	39	0240	6680
390048	39	3240	
390052	39	0280	
390065	39	8840	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5660	5640
390263	0240	6160	
400018	40	1310	
410010	6483	1123	
410013	6483	5523	
420020	42	1440	
420036	42	1520	
420059	42	2655	
420062	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440020	44	3440	
440024	44	1560	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
440050	44	0480	
440058	44	1560	
440059	44	5360	
440067	44	3840	
440068	44	1560	
440073	44	5360	
440083	44	3840	
440143	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440182	44	3580	
440185	44	1560	
440186	44	5360	
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450053	45	8750	
450072	1145	3360	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450113	45	1920	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450155	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45		1920
450211	45	3360	
450214	45	3360	
450224	45	8640	
450246	45	8750	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450587	45	40	
450591	1145	3360	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	320	
460007	46	2620	
460011	46	6520	
460021	46	4120	
460027	46	6520	
460032	46	6520	
460036	46	6520	
460039	46	7160	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
470001	47	1303	
470003	1303	1123	
470011	47	1123	1123
470012	47	6323	
470018	47	1123	
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	1950	
490018	49	4640	
490038	49	3660	
490047	49	8840	
490060	49	3660	
490066	5720	6760	
490079	49	3120	
490126	49	6800	
500002	50	6740	
500003	50	7600	
500007	50	0860	
500016	50	7600	
500041	50	6440	
500059	50	7600	
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520011	52	2290	
520021	3800	1600	1600
520028	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	5080	
520084	52	4720	
520088	52	5080	
520091	52	23	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530008	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]

DRG	Cases	Mean + 1 standard deviation
1	27,704	$66,748
2	14,078	$34,337
3	7	$55,030
4	6,426	$41,870
5	93,104	$23,280
6	398	$14,095
7	14,187	$46,968
8	4,349	$28,253
9	1,737	$24,223
10	18,015	$22,246
11	3,398	$15,519
12	49,619	$15,429
13	6,637	$13,922
14	235,975	$21,928
15	101,681	$16,969
16	9,257	$21,632
17	2,870	$11,541
18	28,000	$17,036
19	8,672	$12,308
20	5,616	$51,920
21	1,429	$27,335
22	2,722	$18,422
23	11,189	$14,276
24	55,342	$17,340
25	27,205	$10,640
26	34	$13,463
27	3,839	$23,063
28	12,339	$23,674
29	4,928	$12,505
31	3,814	$15,329
32	1,891	$9,174
34	22,336	$17,368
35	7,323	$11,138
36	2,481	$10,985
37	1,418	$18,071
38	93	$9,775
39	666	$10,551
40	1,524	$14,863
42	1,936	$11,289
43	110	$8,855
44	1,295	$11,245
45	2,598	$12,352
46	3,373	$13,685
47	1,350	$9,302
49	2,337	$31,134
50	2,477	$13,972
51	251	$16,197
52	238	$13,055
53	2,517	$20,530
55	1,564	$16,073
56	526	$16,460
57	692	$17,299
59	127	$13,165
60	6	$10,986
61	243	$21,950
62	3	$6,623
63	2,900	$25,070
64	3,131	$23,886
65	39,014	$9,512
66	7,668	$9,851
67	439	$13,316
68	8,752	$11,567
69	3,034	$8,666
70	25	$8,029
71	87	$12,279
72	926	$12,429
73	7,070	$13,912
75	39,852	$53,451

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
76	41,676	$50,324
77	2,444	$21,281
78	35,270	$22,207
79	166,273	$29,036
80	8,304	$15,356
81	2	$17,479
82	63,407	$25,645
83	6,390	$16,990
84	1,558	$8,753
85	21,262	$21,607
86	2,179	$12,312
87	59,447	$24,541
88	396,490	$15,658
89	502,217	$18,132
90	46,781	$10,653
91	57	$12,409
92	14,806	$21,600
93	1,710	$13,018
94	12,571	$20,639
95	1,679	$10,242
96	53,684	$13,018
97	28,583	$9,626
98	15	$16,431
99	21,274	$12,269
100	8,941	$9,245
101	21,119	$14,939
102	5,557	$9,489
103	428	$349,756
104	19,511	$130,539
105	27,278	$94,418
106	3,307	$121,657
107	85,660	$86,239
108	6,200	$95,309
109	59,511	$64,065
110	53,164	$71,438
111	9,392	$42,529
113	41,401	$49,111
114	8,849	$29,028
115	15,270	$58,727
116	109,194	$38,515
117	4,176	$23,091
118	8,104	$27,103
119	1,316	$22,646
120	37,306	$39,416
121	167,277	$27,051
122	81,670	$17,860
123	41,145	$28,071
124	138,236	$23,982
125	89,996	$18,048
126	5,015	$48,094
127	681,606	$17,412
128	8,240	$12,365
129	4,100	$19,186
130	88,663	$16,401
131	27,776	$9,821
132	152,256	$11,138
133	8,915	$9,314
134	39,612	$10,344
135	7,552	$15,416
136	1,237	$10,011
138	203,304	$14,336
139	89,960	$8,832
140	66,409	$9,140
141	102,377	$12,604
142	51,706	$9,672
143	250,001	$9,216
144	88,480	$21,330
145	7,594	$10,378

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
146	10,796	$45,993
147	2,797	$25,903
148	129,351	$59,354
149	19,315	$24,710
150	20,330	$49,351
151	4,962	$22,681
152	4,424	$33,239
153	2,013	$19,418
154	28,996	$73,715
155	7,260	$21,846
156	3	$32,596
157	8,151	$22,041
158	4,560	$10,941
159	17,109	$23,315
160	12,156	$13,554
161	11,153	$19,125
162	7,270	$10,677
163	3	$7,876
164	5,116	$39,084
165	2,184	$20,580
166	3,902	$24,579
167	3,799	$14,801
168	1,381	$22,419
169	869	$12,657
170	12,155	$49,736
171	1,359	$19,892
172	30,603	$24,475
173	2,709	$13,824
174	247,084	$17,229
175	35,141	$9,564
176	15,215	$18,581
177	9,422	$15,760
178	3,756	$11,718
179	12,540	$18,881
180	88,253	$16,534
181	27,085	$9,241
182	260,632	$13,956
183	91,215	$9,962
184	93	$8,646
185	5,069	$15,675
186	3	$17,560
187	666	$14,847
188	79,377	$19,332
189	13,104	$10,335
190	74	$12,681
191	9,220	$77,337
192	1,257	$30,601
193	4,862	$59,463
194	733	$27,612
195	4,151	$50,509
196	1,050	$26,194
197	18,557	$42,811
198	5,667	$20,952
199	1,644	$42,977
200	1,042	$53,497
201	2,013	$67,182
202	26,142	$23,012
203	29,301	$24,716
204	61,516	$20,412
205	24,447	$21,124
206	2,048	$12,455
207	32,101	$19,874
208	10,740	$11,426
209	370,349	$31,852
210	121,438	$29,326
211	32,517	$19,885
212	7	$11,988
213	9,875	$32,709

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
216	6,916	$38,905
217	17,022	$53,503
218	22,732	$25,771
219	20,855	$16,751
223	13,650	$17,145
224	12,431	$12,855
225	6,124	$19,539
226	5,698	$26,964
227	4,915	$13,522
228	2,481	$19,438
229	1,175	$11,756
230	2,406	$21,932
231	12,530	$24,031
232	880	$16,464
233	7,178	$34,665
234	4,607	$21,908
235	5,089	$13,039
236	39,744	$12,220
237	1,743	$9,880
238	8,617	$24,817
239	48,197	$17,565
240	11,800	$23,191
241	3,218	$11,428
242	2,515	$19,784
243	93,611	$12,959
244	13,570	$12,429
245	5,726	$8,349
246	1,346	$9,926
247	19,616	$10,001
248	12,060	$14,559
249	12,649	$11,805
250	3,793	$11,824
251	2,489	$8,063
253	20,842	$12,750
254	10,802	$7,656
256	6,400	$14,186
257	16,692	$14,784
258	16,950	$11,403
259	3,812	$15,230
260	5,072	$11,046
261	1,888	$16,770
262	686	$15,951
263	24,560	$37,753
264	3,982	$19,495
265	4,052	$27,077
266	2,676	$14,584
267	267	$15,879
268	899	$19,361
269	9,060	$29,801
270	2,746	$12,961
271	19,594	$18,154
272	5,470	$17,426
273	1,387	$10,047
274	2,343	$22,054
275	247	$10,261
276	1,326	$11,997
277	93,843	$14,927
278	31,720	$9,470
279	3	$19,964
280	17,038	$12,041
281	7,827	$8,003
283	5,635	$12,585
284	1,950	$7,589
285	6,568	$35,890
286	2,183	$35,565
287	6,457	$32,850
288	3,675	$36,854
289	6,414	$16,097

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
290	9,482	$14,860
291	78	$10,570
292	5,422	$44,164
293	345	$24,530
294	95,355	$13,252
295	3,358	$13,707
296	250,808	$14,775
297	47,716	$8,713
298	103	$10,114
299	1,218	$16,149
300	17,532	$19,436
301	3,639	$11,261
302	7,896	$54,753
303	20,698	$41,205
304	12,041	$40,662
305	3,006	$20,536
306	7,210	$21,938
307	2,164	$10,268
308	7,244	$28,300
309	4,331	$15,304
310	24,587	$19,325
311	8,309	$10,483
312	1,547	$18,439
313	644	$11,749
315	33,708	$36,795
316	115,275	$23,727
317	1,889	$12,419
318	5,736	$21,305
319	494	$11,322
320	193,134	$14,735
321	30,723	$9,566
322	64	$8,657
323	18,621	$14,311
324	7,451	$8,122
325	8,937	$11,466
326	2,802	$7,872
327	2	$10,679
328	685	$13,051
329	105	$8,650
331	49,123	$18,734
332	5,117	$10,727
333	311	$13,719
334	10,262	$24,961
335	12,370	$18,084
336	36,313	$14,365
337	29,498	$9,686
338	1,055	$21,430
339	1,505	$18,435
341	3,670	$21,442
342	723	$13,001
344	3,838	$22,438
345	1,335	$19,558
346	4,559	$18,995
347	373	$10,844
348	3,280	$12,862
349	597	$7,194
350	6,493	$12,462
352	768	$12,805
353	2,655	$31,864
354	7,485	$25,534
355	5,670	$14,447
356	25,920	$12,488
357	5,710	$39,602
358	20,605	$20,138
359	31,042	$13,346
360	15,575	$14,638
361	369	$18,778
362	2	$9,180

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
363	2,683	$15,573
364	1,629	$14,738
365	1,834	$34,245
366	4,432	$23,297
367	520	$10,108
368	3,285	$21,162
369	3,279	$10,693
370	1,242	$16,029
371	1,413	$10,589
372	919	$9,639
373	3,876	$6,330
374	116	$12,936
375	8	$21,289
376	262	$8,664
377	29	$24,590
378	169	$15,095
379	408	$6,916
380	76	$6,684
381	181	$10,112
382	25	$2,798
383	1,841	$9,336
384	149	$7,372
389	5	$11,692
392	2,246	$55,515
394	2,326	$31,257
395	100,607	$14,330
396	11	$12,749
397	17,906	$21,719
398	17,113	$22,322
399	1,788	$12,303
400	6,486	$47,400
401	5,836	$50,173
402	1,599	$19,649
403	31,999	$32,078
404	4,588	$15,824
406	2,494	$48,934
407	701	$21,576
408	2,122	$36,343
409	2,515	$21,666
410	30,760	$18,311
411	14	$7,688
412	18	$4,980
413	5,766	$24,842
414	763	$12,866
415	39,905	$66,206
416	181,072	$28,177
417	37	$21,802
418	23,398	$18,311
419	15,719	$15,131
420	2,957	$10,195
421	9,270	$11,869
422	69	$7,590
423	7,269	$31,897
424	1,292	$41,189
425	16,304	$11,890
426	4,481	$9,206
427	1,576	$9,291
428	744	$12,949
429	27,018	$14,174
430	63,051	$12,703
431	320	$10,737
432	411	$11,105
433	5,520	$4,883
439	1,457	$29,345
440	5,435	$32,696
441	612	$15,577
442	16,693	$42,597
443	3,807	$17,673

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
444	5,675	$13,003
445	2,724	$8,465
447	6,278	$8,499
449	30,470	$14,241
450	7,366	$7,229
451	5	$4,039
452	25,215	$18,340
453	5,643	$9,105
454	4,623	$14,423
455	1,096	$8,019
461	4,563	$21,124
462	11,981	$19,956
463	25,204	$12,097
464	7,101	$8,636
465	224	$10,305
466	1,795	$11,397
467	1,043	$9,854
468	54,705	$66,153
470	49	$302,446
471	12,391	$47,581
473	8,235	$63,556
475	104,025	$67,384
476	3,812	$40,882
477	25,600	$32,847
478	108,611	$42,010
479	24,176	$24,354

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
480	622	$176,423
481	726	$123,849
482	5,299	$61,539
483	43,282	$288,420
484	317	$100,224
485	3,028	$50,619
486	1,867	$85,814
487	3,533	$35,194
488	776	$88,052
489	13,548	$32,178
490	5,247	$18,195
491	13,575	$26,985
492	2,874	$74,770
493	58,081	$30,868
494	30,883	$16,784
495	211	$155,662
496	1,841	$98,777
497	19,917	$57,641
498	14,635	$41,713
499	32,659	$24,252
500	49,444	$15,562
501	2,352	$44,432
502	636	$25,677
503	5,888	$20,546
504	123	$281,048
505	147	$31,985

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
506	937	$84,055
507	288	$30,296
508	667	$24,629
509	177	$16,475
510	1,671	$20,337
511	616	$11,613
512	450	$95,226
513	142	$99,439
514	19,241	$104,112
515	4,568	$87,754
516	76,169	$45,006
517	190,940	$36,508
518	51,620	$30,281
519	7,216	$39,899
520	11,045	$25,111
521	28,562	$12,663
522	6,139	$10,035
523	14,802	$6,921
524	136,805	$12,350
525	492	$209,675

[1] Cases are taken from the FY 2001 MedPAR file; DRGs are from GROUPER V20.0.

Appendix A—Regulatory Impact Analysis

I. Introduction

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

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase.

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

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (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 proposed 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 proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

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 proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

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

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

II. Objectives

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

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the Acute Care Hospital Inpatient 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 44 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 67 such hospitals in Maryland remain excluded from the hospital inpatient prospective payment system under the waiver at section 1814(b)(3) of the Act.

There are approximately 515 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the acute care hospital inpatient prospective payment system. The remaining 20 percent are specialty hospitals that are excluded from the acute-care, short-term prospective payment system. These hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

Thus, as of February 2002, we have included 4,301 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

As of February 2002, there were 1,065 specialty hospitals excluded from the

acute care hospital inpatient 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 493 psychiatric, 216 rehabilitation, 270 long-term care, 75 children's, and 11 cancer hospitals. In addition, there were 1,436 psychiatric units and 936 rehabilitation units in hospitals otherwise subject to the acute care hospital inpatient prospective payment system. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 67 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the acute care hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316 through 41430)). Therefore, these hospitals are not impacted by this proposed rule.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals would be paid under a long-term care hospital prospective payment system, where long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416 through 13494)). However, under this proposed payment system, a long-term care hospital may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the proposed estimate of the excluded hospital market basket (or 3.4 percent).

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect 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 hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under the Hospital Inpatient Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the hospital inpatient prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase. We have prepared separate impact analyses of the proposed 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 FY 2001 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 proposed policy changes. Second, due to the interdependent nature of the hospital inpatient prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 2001 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 short-term acute-care hospital inpatient prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. The impact of payments under the capital prospective payment system, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2003 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the proposed change to the labor portion of the standardized amounts from 71.1 percent to 72.5 percent.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 1999, compared to the FY 1998 wage data, and the effects of removing from the wage data the costs and hours associated with graduate medical education (GME) and certified registered nurse anesthetists (CRNAs).
- The effects of the proposed 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 geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2003.

• The total change in payments based on FY 2003 policies relative to payments based on FY 2002 policies.

To illustrate the impacts of the FY 2003 proposed changes, our analysis begins with a FY 2003 baseline simulation model using: the FY 2002 DRG GROUPER (version 19.0); the FY 2002 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2003 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 2002 to FY 2003. Six 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 are proposing to update the large urban and the other areas average standardized amounts for FY 2003 using the most recently forecasted hospital market basket increase for FY 2003 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 Medicare-dependent small rural hospitals (MDHs) is also 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 2002 to FY 2003 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2002 that are no longer reclassified in FY 2003 may have a negative payment impact going from FY 2002 to FY 2003; conversely, hospitals not reclassified in FY 2002 that are reclassified in FY 2003 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 is alleviated, however, 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 2002 will be 6.7 percent of total DRG payments. When the FY 2002 final rule was published, we projected FY 2002 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 2002 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2002 payments per case to estimated FY 2003 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. This option was to be phased in over 4 years. For FY 2003, the proportion of payments based on affected SCHs' FY 1996 hospital-specific amount increases from 50 percent to 75 percent.

Fifth, under section 1886(d)(5)(B)(ii) of the Act, the formula for indirect medical education (IME) is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase.

Sixth, the disproportionate share hospital (DSH) adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003.

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 4,301 hospitals included in the analysis. This number is 494 fewer hospitals than were included in the impact analysis in the FY 2002 final rule (66 FR 40087). Of this number, 437 are now CAHs and are excluded from our analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,613 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,511 hospitals located in large urban areas (populations over 1 million), and 1,102 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,688 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 2003 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 2,645, 1,570, 1,075, and 1,656, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,195 nonteaching hospitals in our analysis, 872 teaching hospitals with fewer than 100 residents, and 234 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.)

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

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (159), SCHs (540), MDHs (216), and hospitals that are both SCH and RRC (75) shown here were not reclassified for purposes of the standardized amount. There are 4 RRCs and 1 SCH and RRC that will be reclassified as urban for the standardized amount in FY 2003 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 were unavailable for 213 hospitals. Similarly, the data needed to determine

Medicare utilization were unavailable for 109 hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2003. 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 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1] (0)	New labor share[2] (1)	DRG changes.[3] (2)	New wage data[4] (3)	Remove GME & CRNA 80/20[5] (4)	Remove GME & CRNA 100 percent[6] (5)	DRG & WI changes[7] (6)	MCGRB reclassification[8] (7)	All FY 2003 changes[9] (8)
By Geographic Location:									
All hospitals	4,301	0.0	−0.2	0.0	0.0	0.0	0.0	0.0	0.4
Urban hospitals	2,613	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.5	0.1
Large urban areas (populations over 1 million)	1,511	0.1	−0.2	−0.2	0.0	0.0	−0.2	−0.5	−0.3
Other urban areas (populations of 1 million of fewer)	1,102	−0.1	−0.1	0.1	0.0	0.0	0.3	−0.4	0.8
Rural hospitals	1,688	−0.2	−0.4	0.5	0.1	0.1	0.3	2.5	2.1
Bed Size (Urban):									
0–99 beds	647	0.0	−0.2	0.0	0.1	0.1	0.3	−0.6	1.5
100–199 beds	904	0.0	−0.3	−0.1	0.0	0.1	0.0	−0.5	1.0
200–299 beds	528	0.0	−0.3	0.0	0.0	0.1	0.1	−0.4	0.5
300–499 beds	387	0.0	−0.1	−0.2	0.0	0.0	0.0	−0.4	0.1
500 or more beds	147	0.1	−0.2	−0.1	0.0	0.0	−0.1	−0.5	−1.1
Bed Size (Rural):									
0–49 beds	819	−0.2	−0.6	0.6	0.1	0.1	0.2	0.5	2.6
50–99 beds	507	−0.2	−0.5	0.4	0.1	0.1	0.2	1.0	2.4
100–149 beds	216	−0.2	−0.4	0.6	0.1	0.1	0.5	2.9	2.0
150–199 beds	78	−0.2	−0.4	0.5	0.1	0.1	0.5	4.8	1.9
200 or more beds	68	−0.2	−0.3	0.4	0.1	0.1	0.4	4.1	1.4
Urban by Region:									
New England	134	0.2	−0.3	0.1	0.0	0.1	0.9	−0.2	0.0
Middle Atlantic	402	0.2	−0.1	−0.8	0.0	0.0	−0.8	−0.1	−1.8
South Atlantic	380	−0.1	−0.2	0.1	0.1	0.1	0.2	−0.5	0.9
East North Central	431	0.0	−0.2	0.1	0.0	0.0	0.2	−0.5	0.4
East South Central	158	−0.2	−0.2	0.2	0.0	0.0	0.1	−0.7	0.9
West North Central	180	−0.1	−0.3	0.5	0.1	0.1	0.6	−0.7	0.9
West South Central	334	−0.2	−0.2	−0.2	0.1	0.1	−0.1	−0.7	0.4
Mountain	132	0.0	0.0	−0.3	0.1	0.1	0.0	−0.6	0.6
Pacific	416	0.2	−0.4	0.0	0.1	0.1	0.1	−0.5	0.7
Puerto Rico	46	−0.7	−0.4	−0.8	0.0	0.0	−0.7	−0.8	0.0
Rural by Region:									
New England	40	0.0	−0.4	0.2	0.0	0.0	0.0	2.8	1.0
Middle Atlantic	68	−0.1	−0.4	−0.1	0.0	0.0	−0.3	2.5	1.6
South Atlantic	239	−0.2	−0.5	0.4	0.1	0.1	0.2	3.0	1.9
East North Central	225	−0.1	−0.3	0.4	0.1	0.1	0.4	2.1	2.5
East South Central	243	−0.3	−0.6	1.0	0.1	0.1	0.8	2.4	2.0
West North Central	311	−0.2	−0.4	0.8	0.0	0.0	0.7	1.5	2.4
West South Central	294	−0.3	−0.6	0.3	0.1	0.1	0.0	3.4	1.8
Mountain	151	−0.1	−0.4	0.2	0.0	0.0	0.1	1.6	2.0
Pacific	112	0.0	−0.4	0.8	0.1	0.1	0.6	2.3	2.7
Puerto Rico	5	−0.7	−0.5	−4.9	0.1	0.1	−5.0	−0.5	−2.8
By Payment Classification:									
Urban hospitals	2,645	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.4	0.2
Large urban areas (populations over 1 million)	1,570	0.1	−0.2	−0.2	0.0	0.0	−0.2	−0.4	−0.2
Other urban areas (populations of 1 million of fewer)	1,075	−0.1	−0.1	0.1	0.0	0.0	0.3	−0.4	0.8
Rural areas	1,656	−0.2	−0.5	0.5	0.1	0.1	0.3	2.4	2.1
Teaching Status:									
Non-teaching	3,195	−0.1	−0.4	0.2	0.1	0.1	0.2	0.3	1.5
Fewer than 100 Residents	872	0.0	−0.1	−0.1	0.0	0.0	0.0	−0.3	0.5
100 or more Residents	234	0.1	−0.2	−0.3	0.0	0.0	−0.3	−0.3	−1.7
Urban DSH:									
Non-DSH	1,565	0.0	−0.1	0.0	0.0	0.0	0.2	0.1	0.7
100 or more beds	1,354	0.0	−0.2	−0.2	0.0	0.0	−0.1	−0.5	0.0
Less than 100 beds	295	0.0	−0.4	0.1	0.1	0.1	0.1	−0.3	1.5

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1] (0)	New labor share[2] (1)	DRG changes.[3] (2)	New wage data[4] (3)	Remove GME & CRNA 80/20[5] (4)	Remove GME & CRNA 100 percent[6] (5)	DRG & WI changes[7] (6)	MCGRB reclassification[8] (7)	All FY 2003 changes[9] (8)
Rural DSH:									
Sole Community (SCH)	470	−0.1	−0.7	0.4	0.0	0.0	−0.1	0.1	2.3
Referral Center (RRC) ...	156	−0.2	−0.4	0.5	0.1	0.1	0.5	5.1	1.6
Other Rural:									
100 or more beds	78	−0.3	−0.5	0.6	0.1	0.1	0.6	1.2	2.0
Less than 100 beds ...	383	−0.3	−0.6	0.7	0.1	0.1	0.5	0.8	2.5
Urban teaching and DSH:									
Both teaching and DSH	758	0.0	−0.2	−0.3	0.0	0.0	−0.2	−0.5	−0.6
Teaching and no DSH ...	278	0.0	0.0	0.0	0.0	0.0	0.2	−0.1	−0.1
No teaching and DSH ...	891	0.0	−0.4	0.1	0.1	0.1	0.2	−0.4	1.4
No teaching and no DSH	718	0.0	−0.2	0.0	0.0	0.1	0.2	−0.4	1.0
Rural Hospital Types:									
Non special status hospitals	666	−0.3	−0.5	0.7	0.1	0.1	0.6	1.2	2.3
RRC	159	−0.3	−0.3	0.6	0.1	0.1	0.6	6.0	1.2
SCH	540	−0.1	−0.6	0.2	0.0	0.0	−0.2	0.3	2.3
Medicare-dependent hospitals (MDH)	216	−0.2	−0.6	0.7	0.1	0.1	0.3	0.5	2.7
SCH and RRC	75	−0.1	−0.3	0.3	0.0	0.0	0.1	1.8	2.5
Type of Ownership:									
Voluntary	2,473	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.1	0.4
Proprietary	705	0.0	−0.2	−0.2	0.1	0.1	−0.1	−0.1	0.3
Government	910	−0.1	−0.5	0.3	0.1	0.1	0.2	0.2	0.8
Unknown	213	−0.1	−0.3	0.2	0.1	0.1	0.2	−0.4	0.6
Medicare Utilization as a Percent of Inpatient Days:									
0–25	319	0.1	−0.4	−0.3	0.1	0.1	−0.4	−0.3	−0.7
25–50	1,650	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.3	0.0
50–65	1,706	−0.1	−0.2	0.1	0.0	0.0	0.2	0.3	1.1
Over 65	517	−0.1	−0.4	−0.1	0.0	0.0	−0.1	0.5	0.6
Unknown	109	0.2	0.1	−1.1	0.0	0.0	−0.8	−0.7	−0.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2003 Reclassifications:									
All Reclassified Hospitals	620	−0.1	−0.3	0.3	0.0	0.1	0.4	4.4	1.0
Standardized Amount Only	29	0.0	−0.4	0.6	0.1	0.1	0.6	0.3	1.6
Wage Index Only	527	−0.1	−0.3	0.3	0.0	0.1	0.3	4.5	0.8
Both	41	−0.2	−0.2	0.4	0.1	0.1	0.6	5.1	1.1
Nonreclassified Hospitals	3,666	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.7	0.3
All Reclassified Urban Hospitals	108	0.1	−0.1	0.1	0.0	0.0	0.4	4.0	−0.4
Standardized Amount Only	1	0.0	−0.1	0.4	−0.1	−0.1	0.4	−0.9	1.6
Wage Index Only	95	0.1	−0.1	0.1	0.0	0.0	0.4	4.1	0.6
Both	12	−0.1	−0.2	0.6	0.1	0.1	0.9	2.9	4.1
Urban Nonreclassified Hospitals	2,471	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.7	0.2
All Reclassified Rural Hospitals	512	−0.2	−0.4	0.4	0.1	0.1	0.4	4.6	1.8
Standardized Amount Only	1	−0.4	0.1	0.1	0.1	0.1	0.6	0.9	3.7
Wage Index Only	502	−0.2	−0.4	0.5	0.1	0.1	0.4	4.6	1.8
Both	9	−0.2	−0.2	0.2	0.1	0.1	0.2	4.7	0.7
Rural Nonreclassified Hospitals	1,175	−0.2	−0.6	0.5	0.1	0.1	0.3	−0.4	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	−0.1	−0.6	−0.1	0.0	0.0	−0.5	−1.4	2.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2001, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

[2] This column displays impact of the proposed change to the labor share from 71.1 percent to 72.5 percent.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 2001 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column displays the impact of updating the wage index with wage data from hospitals' FY 1999 cost reports.

[5] This column displays the impact of an 80/20 percent blend of removing the labor costs and hours associated with graduate medical education and for the Part A costs of certified registered nurse anesthetists.

[6] This column displays the impact of completely removing the labor costs and hours associated with graduate medical education (GME) and for the Part A costs of certified registered nurse anesthetists (CRNAs).

[7] 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 phase-out of GME and CRNA costs and hours, and the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the FY 2003 budget neutrality factor of 1.001026.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2003 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2003. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 2002 to FY 2003. It incorporates all of the changes displayed in columns 1, 6 and 7 (the changes displayed in columns 2, 3, 4, and 5 are included in column 6). It also displays the impact of the FY 2003 update, changes in hospitals' reclassification status in FY 2003 compared to FY 2002, and the difference in outlier payments from FY 2002 to FY 2003. It also reflects the gradual phase-in for some SCHs of the full 1996 hospital-specific rate. Finally, the impacts of the reduction in IME adjustment payments, and the increase in the DSH adjustment are shown in this column. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

B. Impact of the Proposed Changes to the Labor Share (Column 1)

In Column 1 of Table 1, we present the effects of our proposal to update the labor share from 71.10 percent to 72.49 percent. We estimate the impact of this change by calculating payments using payment rates updated to FY 2003, but using the FY 2002 DRG GROUPER and wage index. The change in this column represents the impact upon various hospital categories of the proposed change to the labor share. This proposed change negatively impacts hospitals with wage indexes less than 1.0, and positively affects those with wage indexes greater than 1.0.

This proposed change has no impact on overall hospital payments. However, there are redistributive impacts generally in the range of plus or minus 0.1 percent or 0.2 percent. The net redistributive impact from those positively and negatively affected is approximately $65 million. Hospitals in large urban areas would experience an increase of 0.1 percent. Hospitals in both ''other'' urban and rural areas would experience −0.1 and −0.2 percent decreases, respectively.

Under the urban by region category, New England, Middle Atlantic and Pacific regions would experience a 0.2 percent increase. The urban East South Central and West South Central regions would experience −0.2 percent decreases. Puerto Rico has a projected decrease of −0.7 percent, due to the low wage indexes in the Puerto Rico MSAs.

All rural regions would experience a negative percent decrease except New England and Pacific regions (at 0.0 percent change). The South Atlantic and West North Central regions would experience a decrease of −0.2 percent. The East South Central and West South Central regions each would experience a −0.3 percent decrease, while Puerto Rico would experience a −0.7 percent decrease. Rural nonspecial status hospitals and RRCs would decline by −0.3. SCH and MDHs also would experience decreases of −0.1 and −0.2 percent, respectively. The relatively smaller negative impact for these hospitals is due to the fact that the hospital-specific rate is not adjusted by the wage index. Therefore, this proposed change would have no effect on hospitals paid on that basis (other than SCHs receiving a blended of their FY 1996 hospital-specific rate and the Federal rate).

C. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 3)

In column 3 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us 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 2002 DRG relative weights (GROUPER version 19.0) to aggregate payments using the proposed FY 2003 DRG relative weights (GROUPER version 20.0). Overall payments decrease −0.2 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 changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 1.001026 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The DRG changes we are proposing would result in 0.2 percent lower payments to hospitals overall. This is the reason the budget neutrality factor is greater than 1.0. This change is largely related to the proposed changes we are making to DRGs 14 (proposed to be retitled, Intracranial Hemorrhage and Stroke with Infarction) and 15 (proposed to be retitled, Nonspecific Cerebrovascular and Precerebral Occlusion without Infarction), and new DRG 524 (Transient Ischemia). With the new configuration of these DRGs, over 80,000 cases that previously would have been assigned to DRG 14 (with a FY 2003 proposed relative weight of 1.2742) would now be assigned to DRG 15 (with a FY 2003 proposed relative weight of 0.9844).

This change is evident most dramatically in small and rural hospitals. Rural hospitals with fewer than 50 beds would experience a 0.6 percent decrease, and rural hospitals with between 50 and 99 beds would experience a 0.5 percent decrease. Among rural hospitals categorized by region, the East South Central and West South Central would experience a 0.6 percent decrease in payments. Among special rural hospital categories, SCHs and MDHs both would experience 0.6 percent decreases.

D. Impact of Wage Index Changes (Columns 3, 4, and 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2003 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999. As with column 2, the impact of the new data on hospital payments is isolated in columns 3, 4 and 5 by holding the other payment parameters constant in the three simulations. That is, columns 3, 4, and 5 show the percentage changes in payments when going from a model using the FY 2002 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY 2003 pre-

reclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1999 cost reports are similar to the data used in the calculation of the FY 2002 wage index. Also, as described in section III.B of this preamble, the proposed FY 2003 wage index is calculated by removing 100 percent of hospitals' GME and CRNA costs (and hours). The FY 2002 wage index was calculated by blending 60 percent of hospitals' average hourly wages, excluding GME and CRNA data, with 40 percent of average hourly wages including these data.

Column 3 shows the impacts of updating the wage data using FY 1999 cost reports. This column maintains the same 60/40 phase-out of GME and CRNA costs as the FY 2002 wage index, which is the baseline for comparison. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.9 percent decrease). Rural hospitals in the East South Central region experience the next largest impact, a 1.0 percent increase. This is primarily due to a 6 percent increase in the rural Alabama wage index, and a little under a 3 percent increase in the rural Mississippi wage index. Among urban hospitals, the Middle Atlantic region would experience a 0.8 percent decrease, largely due to a 2.4 percent decrease in the New York City wage index and a 2.3 percent decrease in the Philadelphia wage index.

The next two columns show the impacts of removing the GME and CRNA data from the wage index calculation. Under the 5-year phaseout of these data, FY 2003 would be the fourth year of the phaseout. This means that, under the phaseout, the FY 2003 wage index would be calculated with 20 percent of the GME and CRNA data included and 80 percent with these data removed, and FY 2004 would begin the calculation with 100 percent of these data removed. However, we are proposing to remove 100 percent of GME and CRNA costs from the FY 2003 wage index. To demonstrate the impacts of this proposal, we first show the impacts of moving to a wage index with 80 percent of these data removed (Column 4), then show a wage index with 100 percent of these data removed (Column 5). As expected, the impacts in the two columns are similar, with some differences due to rounding. Generally, no group of hospitals is impacted by more than 0.1 percent by this change. Even among the hospital group most likely to be negatively impacted by this change, teaching hospitals with 100 or more residents, the net effect of removing 100 percent of GME and CRNA data is 0.0 percent change in payments.

We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 2001 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions will be reflected in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The following chart compares the shifts in wage index values for labor market areas for FY 2002 relative to FY 2003. This chart demonstrates the impact of the proposed changes for the FY 2003 wage index, including updating to FY 1999 wage data and removing 100 percent of GME and CRNA data. The majority of labor market areas (324) experience less than a 5 percent change. A total of 19 labor market areas experience an increase of more than 5 percent and less than 10 percent. One area experiences an increase greater than 10 percent. A total of 26 areas experience decreases of more than 5 percent and less than 10 percent. Finally, 2 areas experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2002	FY 2003
Increase more than 10 percent	2	1
Increase more than 5 percent and less than 10 percent	26	19
Increase or decrease less than 5 percent	335	320
Decrease more than 5 percent and less than 10 percent	10	26
Decrease more than 10 percent	1	2

Among urban hospitals, 24 would experience an increase of between 5 and 10 percent and 2 more than 10 percent. A total of 53 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 75 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Six urban hospitals have decreases in their wage index values greater than 10 percent. There are 19 rural hospitals with decreases in their wage index values greater than 5 percent or with increases of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	2	0
Increase more than 5 percent and less than 10 percent	24	53
Increase or decrease less than 5 percent	2506	1616
Decrease more than 5 percent and less than 10 percent	75	19
Decrease more than 10 percent	6	0

E. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 6)

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 proposed rule, we compared simulated aggregate payments using the FY 2002 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2003 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 1.001026. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 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 2, 3, 4, and 5, plus approximately 0.1 percent attributable to the budget neutrality factor. In addition, 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. This provision is required to be budget neutral. The impact of this provision, which is to increase overall payments by 0.1 percent, is not shown in columns 2, 3, 4, and 5. It is included in the impacts shown in column 6. There also may be some variation of plus or minus 0.1 percent due to rounding.

F. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2003. These decisions affect hospitals' standardized amount and wage index area assignments.

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

The proposed FY 2003 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2003. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process for MGCRB decisions as of February 28, 2002. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2003.

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 0.990536 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.5 percent in column 6. Payments to urban hospitals decline 0.5 percent. Hospitals in other urban areas see a decrease in payments of 0.5 percent, while large urban hospitals lose 0.5 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 smallest increases among the rural census divisions are 1.5 and 1.6 percent for West North Central and Mountain regions, respectively. The largest increases are in rural South Atlantic and West South Central regions. These regions receive increases of 3.0 and 3.4 percent, respectively.

Among all the hospitals that were reclassified for FY 2003 (including hospitals that received wage index reclassification in a FY 2001 or FY 2002 that extend for 3-years), the MGCRB changes are estimated to provide a 4.4 percent increase in payments. Urban hospitals reclassified for FY 2003 are expected to receive an increase of 4.0 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.6 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 0.3 percent is expected, while those reclassified for purposes of the wage index only show a 4.5 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.7 for urban hospitals and 0.4 for rural hospitals. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive a decrease in payments of 1.4 percent.

The foregoing analysis was based on MGCRB and CMS Administrator decisions made by February 28, 2002. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

G. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2003 (including statutory changes), to our estimate of payments per case in FY 2002. This column includes all of the policy changes to date, including the proposed new labor share shown in column 1, and the combined DRG and wage index changes from column 6. Because the reclassifications shown in column 7 do not reflect FY 2002 reclassifications, the impacts of FY 2003 reclassifications only affect the impacts from FY 2002 to FY 2003 if the reclassification impacts for any group of hospitals are different in FY 2003 compared to FY 2002.

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 1.7 percentage point difference between the projected outlier payments in FY 2002 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2002 (6.8 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

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 2003, eligible SCHs that rebase receive a hospital-specific rate comprised of 25 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their Federal rate, and 75 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

Under section 1886(d)(5)(B)(ii) of the Act, the formula for IME is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase. We estimate the impact of this change to be a 0.9 percent reduction in hospitals' overall FY 2003 payments. The impact upon teaching hospitals would be larger.

Finally, the DSH adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003. The estimated impact of this change is to increase overall hospital payments by 0.2 percent.

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 6 and 7, plus the other impacts that we are able to identify.

The overall change in payments per case for hospitals in FY 2003 increases by 0.4 percent. This reflects the update of 2.75 percent, the 1.7 percent higher outlier payments in FY 2002 than projected for FY 2003, a 0.9 percent reduction in payments for IME, and a 0.2 percent increase in payments due to higher DSH payments in FY 2003. Hospitals in urban areas experience a 0.1 percent increase in payments per case compared to FY 2002, although hospitals in large urban areas experience a 0.3 percent decline in payments, largely due to reduction in IME payments. The impact of the reduction in IME payments is most evident among teaching hospitals with 100 or more residents, who would experience a decrease in payments per case of 1.7 percent. Hospitals in rural areas, meanwhile, experience a 2.1 percent payment increase.

Among urban census divisions, the largest payment increase was 0.9 percent in South Atlantic, East South Central, and West North Central. Hospitals in urban Middle Atlantic would experience an overall decrease of 1.8 percent. This is primarily due to the combination of the negative impact on these hospitals of reducing IME and the lower outlier payments during FY 2003. The rural census division experiencing the smallest increase in payments were New England and the Middle Atlantic regions (1.0 and 1.6 percent, respectively). The only decreases by rural hospitals are in Puerto Rico, where payments appear to decrease by 2.8 percent, largely due to the updated wage data. In the Pacific, payments appear to increase by 2.7 percent. Rural East and West North Central regions also benefited, with 2.5 and 2.4 percent increases, 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 2.3 percent, 2.7 percent, and 2.5 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2002 to FY 2003 (from 6.8 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 2003, hospitals overall are estimated to receive a 1.0 percent increase in payments. Urban hospitals reclassified for FY 2003 are anticipated to receive a decrease of −0.4 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 1.8 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 1.6 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 0.8 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 2.8 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
By Geographic Location:				
All hospitals	4,301	7,194	7,224	0.4
Urban hospitals	2,613	7,707	7,718	0.1
Large urban areas (populations over 1 million)	1,511	8,269	8,245	–0.3
Other urban areas (populations of 1 million of fewer)	1,102	6,977	7,034	0.8
Rural hospitals	1,688	5,108	5,213	2.1
Bed Size (Urban):				
0–99 beds	647	5,299	5,380	1.5
100–199 beds	904	6,436	6,498	1.0
200–299 beds	528	7,391	7,425	0.5
300–499 beds	387	8,276	8,280	0.1
500 or more beds	147	10,046	9,932	–1.1
Bed Size (Rural):				
0–49 beds	819	4,204	4,313	2.6
50–99 beds	507	4,754	4,866	2.4
100–149 beds	216	5,052	5,154	2.0
150–199 beds	78	5,494	5,600	1.9
200 or more beds	68	6,651	6,742	1.4
Urban by Region:				
New England	134	8,228	8,225	0.0
Middle Atlantic	402	8,832	8,675	–1.8
South Atlantic	380	7,287	7,353	0.9
East North Central	431	7,269	7,296	0.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
East South Central	158	6,919	6,984	0.9
West North Central	180	7,330	7,399	0.9
West South Central	334	7,089	7,121	0.4
Mountain	132	7,505	7,553	0.6
Pacific	416	9,319	9,383	0.7
Puerto Rico	46	3,310	3,311	0.0
Rural by Region:				
New England	40	6,227	6,290	1.0
Middle Atlantic	68	5,345	5,430	1.6
South Atlantic	239	5,221	5,319	1.9
East North Central	225	5,059	5,185	2.5
East South Central	243	4,723	4,819	2.0
West North Central	311	5,093	5,214	2.4
West South Central	294	4,547	4,627	1.8
Mountain	151	5,424	5,531	2.0
Pacific	112	6,592	6,772	2.7
Puerto Rico	5	2,754	2,677	–2.8
By Payment Classification:				
Urban hospitals	2,645	7,691	7,703	0.2
Large urban areas (populations over 1 million)	1,570	8,194	8,175	–0.2
Other urban areas (populations of 1 million of fewer)	1,075	7,003	7,057	0.8
Rural areas	1,656	5,094	5,199	2.1
Teaching Status:				
Non-teaching	3,195	5,866	5,952	1.5
Fewer than 100 Residents	872	7,479	7,515	0.5
100 or more Residents	234	11,431	11,239	–1.7
Urban DSH:				
Non-DSH	1,565	6,538	6,581	0.7
100 or more beds	1,354	8,299	8,299	0.0
Less than 100 beds	295	5,235	5,312	1.5
Rural DSH:	470	4,938	5,053	2.3
Sole Community (SCH).				
Referral Center (RRC)	156	5,906	6,001	1.6
Other Rural:				
100 or more beds	78	4,509	4,598	2.0
Less than 100 beds	383	4,076	4,179	2.5
Urban teaching and DSH:				
Both teaching and DSH	758	9,185	9,134	–0.6
Teaching and no DSH	278	7,724	7,717	–0.1
No teaching and DSH	891	6,510	6,600	1.4
No teaching and no DSH	718	6,066	6,124	1.0
Rural Hospital Types:				
Non special status hospitals	666	4,247	4,345	2.3
RRC	159	5,667	5,737	1.2
SCH	540	5,223	5,344	2.3
Medicare-dependent hospitals (MDH)	216	4,032	4,142	2.7
SCH and RRC	75	6,429	6,589	2.5
Type of Ownership:				
Voluntary	2,473	7,322	7,349	0.4
Proprietary	705	6,907	6,929	0.3
Government	910	6,764	6,815	0.8
Unknown	213	7,281	7,326	0.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	319	9,820	9,755	–0.7
25–50	1,650	8,252	8,252	0.0
50–65	1,706	6,225	6,293	1.1
Over 65	517	5,645	5,679	0.6
Unknown	109	8,871	8,832	–0.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2002 Reclassifications:				
All Reclassified Hospitals	620	6,513	6,579	1.0
Standardized Amount Only	29	5,918	6,016	1.6
Wage Index Only	527	6,678	6,728	0.8
Both	41	5,874	5,936	1.1
All Nonreclassified Hospitals	3,666	7,310	7,335	0.3
All Urban Reclassified Hospitals	108	8,752	8,720	–0.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
Urban Nonreclassified Hospitals	1	5,484	5,569	1.6
Standardized Amount Only	95	9,003	8,951	–0.6
Wage Index Only	12	5,680	5,911	4.1
Both	2,471	7,672	7,685	0.2
All Reclassified Rural Hospitals	512	5,666	5,768	1.8
Standardized Amount Only	1	5,408	5,605	3.7
Wage Index Only	502	5,650	5,754	1.8
Both	9	6,370	6,415	0.7
Rural Nonreclassified Hospitals	1,175	4,478	4,585	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	4,892	5,031	2.8

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

Table II presents the projected impact of the proposed changes for FY 2003 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 2002 with the average estimated per case payments for FY 2003, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Specific Proposed Policy Changes

A. Impact of Proposed Policy Changes Relating to Hospital Bed Counts

As discussed in section V.E.3. of the preamble of this proposed rule, we are proposing that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent.

We have calculated an estimated impact on the Medicare program for FY 2003 as a result of this policy. We first identified urban hospitals receiving DSH with bed counts above 100, but with occupancy rates below 35 percent. Then, we determined the amount of DSH payments made to these hospitals in FY 1999. Next, we simulated what these hospitals' DSH payments would have been had their bed counts been less than 100. We compared the difference between actual DSH payments using 100 or more beds to simulated DSH payments using fewer than 100 beds, and determined that the reductions in DSH payments to these hospitals, inflated to FY 2003 using the update to the average standardized amount, would be approximately $38.9 million.

B. Impact of Proposed Changes Relating to EMTALA Provisions

In section V.J. of the preamble to this proposed rule, we discuss our proposed changes to our policies relating to the responsibilities of Medicare-participating hospitals under the patient antidumping statute (EMTALA) to medically screen all patients seeking emergency services and provide stabilizing medical treatment as necessary to patients whose conditions warrant it. In summary, to help promote consistent application of our regulations concerning EMTALA, we are proposing to clarify certain policies in areas where issues have arisen and at the same time address concerns about EMTALA raised by the Secretary's Regulatory Reform Task Force, including the following:

- We are proposing to change the requirements relating to emergency patients presenting at those off-campus outpatient clinics that do not routinely provide emergency services. We believe these changes would enhance the quality and promptness of emergency care by permitting individuals to be referred to appropriately equipped emergency facilities close to such clinics.
- We are proposing to clarify when EMTALA applies to both inpatients and outpatients. We believe these clarifications would enhance overall patient access to emergency services by helping to relieve administrative burdens on frequently overcrowded emergency departments.
- We are proposing to clarify the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff ''on-call'' lists. We expect these clarifications would help improve access to physician services for all hospital patients by permitting hospitals local flexibility to determine how best to maximize their available physician resources. We are currently aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals, especially when those physicians belong to more than one hospital medical staff. Physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. Our proposed clarification of the on-call list requirement would permit hospitals to continue to attract physicians to serve on their medical staffs and thereby continue to provide services to emergency room patients.
- We are proposing to clarify the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with citywide and local community EMS procedures for responding to medical emergencies and thus use these resources more efficiently for the benefit of these communities.

We believe it would be difficult to quantify the impact of these changes and are soliciting comments on these issues.

C. Impact of Proposed Policy Changes Relating to Provider-Based Entity

In section V.K. of the preamble of this proposed rule, we discuss our proposed Medicare payment policy changes relating to determinations of provider-based status for entities of main providers. These changes are intended to focus mainly on issues raised by the hospital industry surrounding the provider-based regulations and to allow for a orderly and uniform implementation strategy once the

grandfathering provision for these entities expires on September 30, 2002.

We believe it would be difficult to quantify the impact of these changes and are soliciting comments on these issues.

VIII. Impact of Proposed Policies Affecting Rural Hospitals

A. Raising the Threshold To Qualify for the CRNA Pass-Through Payments

In section V. of the preamble of this proposed rule, we are proposing to raise the maximum number of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that a rural hospital may perform to qualify for pass-through payments for the costs of CRNAs to 800 from 500. Currently, we have identified 622 hospitals that qualify under this provision.

To measure the impact of this provision, we determined that approximately half of the hospitals that would appear to be eligible based on the current number of procedures appear to receive this adjustment. In order to be eligible, hospitals must employ the CRNA and the CRNA must agree not to bill for services under Part B. We estimate approximately 90 rural hospitals would qualify under the increased maximum volume threshold. If one-half of these hospitals then met the other criteria, 45 additional hospitals would be eligible for these pass-through payments under this proposed change.

B. Removal of Requirement for CAHs To Use State Resident Assessment Instrument

In section VII. of the preamble of this proposed rule, we are proposing to eliminate the requirement that CAHs use the State resident assessment instrument (RAI) to conduct patient assessments. There are approximately 600 CAHs. The overwhelming majority of CAHs, 95 percent, provide SNF level care. The elimination of the requirement to use the State RAI would greatly reduce the burden on CAHs because facilities would no longer be required to complete an RAI document for each SNF patient (which would involve approximately 12,000 admissions based on the most recent claims data). Facilities would have the flexibility to document the assessment data in the medical record in a manner appropriate for their facility. The elimination of the requirement for use of the State RAI would reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

IX. Impact of Proposed Changes in the Capital Prospective Payment System

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the Federal rate (see § 412.344). As we state in section VI.A. of the preamble of this proposed rule, the end of the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), capital prospective payment system payments for most hospitals are based solely on the Federal rate in FY 2003. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

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

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

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

The data used in developing the impact analysis presented below are taken from the December 2001 update of the FY 2001 MedPAR file and the December 2001 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2001 update of the most recently available hospital cost report data (FY 1999) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2001 update of the FY 2001 MedPAR file, we simulated payments under the capital prospective payment system for FY 2002 and FY 2003 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

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

- We estimate that the Medicare case-mix index will increase by 0.99800 percent in FY 2002 and will increase by 1.01505 percent in FY 2003.
- We estimate that the Medicare discharges will be 13,398,000 in FY 2002 and 13,658,000 in FY 2003 for a 1.9 percent increase from FY 2002 to FY 2003.
- The Federal capital rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2003 update is 1.1 percent (see section III.A.1.a. of the Addendum to this proposed rule).

• In addition to the proposed FY 2003 update factor, the proposed FY 2003 Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0224, a proposed outlier adjustment factor of 0.9460, a proposed exceptions adjustment factor of 0.9960, and a proposed special adjustment for FY 2003 of 1.0255 (see section III.A. of the Addendum of this proposed rule).

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under proposed § 412.32(c)(2)) are paid 100 percent of the Federal rate in FY 2003.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2003 on total capital payments per case, using a universe of 4,300 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2001 update of the MedPAR file, the December 2001 update to the Provider-Specific File, and the most recent cost report data. In Table III, we present a comparison of total payments per case for FY 2002 compared to FY 2003 based on proposed FY 2003 payment policies. Column 3 shows estimates of payments per case under our model for FY 2002. Column 4 shows estimates of payments per case under our model for FY 2003. Column 5 shows the total percentage change in payments from FY 2002 to FY 2003. The change represented in Column 5 includes the 1.1 percent increase in the Federal rate, a 1.01505 percent increase in case-mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 3.7 percent in FY 2003. 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 (3.5 percent and 5.1 percent, respectively). This difference is due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2002 to FY 2003 compared to rural hospitals.

All regions are estimated to receive an increase in total capital payments per case, partly due to the elimination of the 2.1 percent reduction to the Federal rate for FY 2003 (see section VI.D. of the preamble of this proposed rule). Changes by region vary from a minimum increase of 2.1 percent (Middle Atlantic urban region) to a maximum increase of 5.7 percent (West North Central rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 4.3 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (4.4 percent). Similarly, payments to voluntary hospitals will increase 3.9 percent, while payments to proprietary hospitals will increase 2.0 percent.

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

To present the effects of the hospitals being reclassified for FY 2003 compared to the effects of reclassification for FY 2002, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2003 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 2003 as a whole are projected to experience a 4.2 percent increase in payments. Payments to nonreclassified hospitals will increase slightly less (3.6 percent) than reclassified hospitals, overall. Hospitals reclassified during both FY 2002 and FY 2003 are projected to receive an increase in payments of 3.9 percent. Hospitals reclassified during FY 2003 only are projected to receive an increase in payments of 9.0 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
By Geographic Location:				
All hospitals	4,300	667	692	3.7
Large urban areas (populations over 1 million)	1,511	773	798	3.1
Other urban areas (populations of 1 million of fewer)	1,102	652	678	4.0
Rural areas	1,687	448	471	5.1
Urban hospitals	2,613	721	746	3.5
0–99 beds	647	511	533	4.3
100–199 beds	904	611	634	3.7
200–299 beds	528	692	717	3.6
300–499 beds	387	762	790	3.7
500 or more beds	147	935	961	2.8
Rural hospitals	1,687	448	471	5.1
0–49 beds	818	370	393	6.0

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

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
50–99 beds	507	412	435	5.6
100–149 beds	216	454	477	5.1
150–199 beds	78	493	517	4.9
200 or more beds	68	566	589	4.1
By Region:				
Urban by Region	2,613	721	746	3.5
New England	134	771	804	4.3
Middle Atlantic	402	817	834	2.1
South Atlantic	380	690	716	3.7
East North Central	431	687	718	4.5
East South Central	158	649	675	4.0
West North Central	180	703	735	4.6
West South Central	334	666	685	2.9
Mountain	132	695	724	4.2
Pacific	416	841	866	2.9
Puerto Rico	46	305	319	4.3
Rural by Region	1,687	448	471	5.1
New England	40	549	575	4.6
Middle Atlantic	68	472	497	5.4
South Atlantic	239	467	489	4.8
East North Central	225	456	481	5.5
East South Central	243	414	435	5.0
West North Central	311	440	465	5.7
West South Central	294	403	423	5.0
Mountain	150	460	483	5.0
Pacific	112	528	557	5.5
By Payment Classification:				
All hospitals	4,300	667	692	3.7
Large urban areas (populations over 1 million)	1,570	767	791	3.2
Other urban areas (populations of 1 million of fewer)	1,075	654	680	4.0
Rural areas	1,655	447	469	5.1
Teaching Status:				
Non-teaching	3,194	545	568	4.2
Fewer than 100 Residents	872	699	726	3.8
100 or more Residents	234	1,041	1,069	2.7
Urban DSH:				
100 or more beds	1,354	759	784	3.3
Less than 100 beds	295	492	512	4.2
Rural DSH:				
Sole Community (SCH/EACH)	469	392	414	5.6
Referral Center (RRC/EACH)	156	518	540	4.3
Other Rural:				
100 or more beds	78	418	439	5.0
Less than 100 beds	383	378	400	5.8
Urban teaching and DSH:				
Both teaching and DSH	758	838	864	3.1
Teaching and no DSH	278	746	776	4.0
No teaching and DSH	891	600	623	3.8
No teaching and no DSH	718	600	623	3.8
Rural Hospital Types:				
Non special status hospitals	666	398	420	5.5
RRC/EACH	159	526	548	4.2
SCH/EACH	539	415	438	5.5
Medicare-dependent hospitals (MDH)	216	368	391	6.3
SCH, RRC and EACH	75	503	530	5.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2002 and FY2003:				
Reclassified During Both FY2002 and FY2003	567	588	611	3.9
Reclassified During FY2003 Only	53	516	563	9.0
Reclassified During FY2002 Only	77	623	651	4.4
FY2003 Reclassifications:				
All Reclassified Hospitals	620	583	607	4.2
All Nonreclassified Hospitals	3,645	683	708	3.6
All Urban Reclassified Hospitals	108	799	826	3.4
Urban Nonreclassified Hospitals	2,471	718	743	3.5
All Reclassified Rural Hospitals	512	500	524	4.7
Rural Nonreclassified Hospitals	1,174	389	411	5.7
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	454	484	6.4

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

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
Type of Ownership:				
Voluntary	2,473	680	707	3.9
Proprietary	705	658	671	2.0
Government	909	600	627	4.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	318	859	885	3.0
25–50	1,650	767	792	3.3
50–65	1,706	582	606	4.2
Over 65	517	525	547	4.3

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Appendix B—Report to Congress

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 2 2002

The Honorable Richard B. Cheney
President of the Senate
Washington, DC 20510

Dear Mr. President:

I am pleased to submit to Congress this letter containing my recommendation for the applicable percentage increase in Medicare's hospital inpatient prospective payment system (IPPS) rates for Federal fiscal year (FY) 2003. Also included are my recommendations for updates to the payment limits for hospitals and hospital units excluded from IPPS, and for adjustments to the diagnosis-related group (DRG) weighting factors.

Section 1886(e)(3) of the Social Security Act (the Act) directs the Secretary of the Department of Health and Human Services to report to the Congress his initial estimate of his recommendation (required by section 1886(e)(4) of the Act) of an appropriate payment update for inpatient hospital services for the upcoming FY. Consistent with current law, the President's FY 2003 budget includes an update to the standardized amounts (the base dollar amounts for IPPS payments) equal to the market basket (an index of inflation in goods and services used by hospitals) minus 0.55 percentage points. The President's FY 2003 budget estimated the IPPS market basket rate of increase for FY 2003 to be 2.8 percent. Based on this estimate, I am recommending an update to the standardized amounts for hospitals in both large urban and other areas of 2.25 percent. Payments to hospitals under IPPS are projected to increase by $2.1 billion, from $86.0 billion in FY 2002 to $88.1 billion in FY 2003.

Although payments for most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of either 1982, 1987, or 1996) or the IPPS rate based on the standardized amount. Consistent with current law and the President's FY 2003 budget, I am recommending an update equal to 2.25 percent to the hospital-specific rate for both sole community hospitals and Medicare-dependent, small rural hospitals.

I am also submitting, consistent with Section 1886(e)(3) of the Act, my recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from IPPS.

The excluded hospital types are: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long-term care hospitals; and cancer hospitals. The types of excluded distinct-part hospital units are psychiatric and rehabilitation. Hospitals and units excluded from the IPPS have in the past been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Page 2 — The Honorable Richard B. Cheney

Psychiatric hospitals and units, and children's and cancer hospitals continue to be paid based on their reasonable costs subject to TEFRA limits. For these hospitals, the President's FY 2003 budget incorporates an increase to the TEFRA limit using 2.8 percent for the excluded hospital market basket increase.

Inpatient rehabilitation facilities (IRF) are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF PPS amount, updated annually.

Effective for cost reporting periods beginning on or after October 1, 2002, we are proposing that long-term care hospitals will be paid under a PPS based on a 5-year transition period (hospitals may elect to receive full PPS rather than transition payments.) For purposes of the update factor, the portion of the proposed PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long term care hospital's TEFRA limit by 2.8 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2003 budget. A final recommendation on the appropriate percentage increases for FY 2003 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC).

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2003.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,

Tommy G. Thompson

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 2 2002

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am pleased to submit to Congress this letter containing my recommendation for the applicable percentage increase in Medicare's hospital inpatient prospective payment system (IPPS) rates for Federal fiscal year (FY) 2003. Also included are my recommendations for updates to the payment limits for hospitals and hospital units excluded from IPPS, and for adjustments to the diagnosis-related group (DRG) weighting factors.

Section 1886(e)(3) of the Social Security Act (the Act) directs the Secretary of the Department of Health and Human Services to report to the Congress his initial estimate of his recommendation (required by section 1886(e)(4) of the Act) of an appropriate payment update for inpatient hospital services for the upcoming FY. Consistent with current law, the President's FY 2003 budget includes an update to the standardized amounts (the base dollar amounts for IPPS payments) equal to the market basket (an index of inflation in goods and services used by hospitals) minus 0.55 percentage points. The President's FY 2003 budget estimated the IPPS market basket rate of increase for FY 2003 to be 2.8 percent. Based on this estimate, I am recommending an update to the standardized amounts for hospitals in both large urban and other areas of 2.25 percent. Payments to hospitals under IPPS are projected to increase by $2.1 billion, from $86.0 billion in FY 2002 to $88.1 billion in FY 2003.

Although payments for most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of either 1982, 1987, or 1996) or the IPPS rate based on the standardized amount. Consistent with current law and the President's FY 2003 budget, I am recommending an update equal to 2.25 percent to the hospital-specific rate for both sole community hospitals and Medicare-dependent, small rural hospitals.

I am also submitting, consistent with Section 1886(e)(3) of the Act, my recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from IPPS.

The excluded hospital types are: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long-term care hospitals; and cancer hospitals. The types of excluded distinct-part hospital units are psychiatric and rehabilitation. Hospitals and units excluded from the IPPS have in the past been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Psychiatric hospitals and units, and children's' and cancer hospitals continue to be paid based on their reasonable costs subject to TEFRA limits. For these hospitals, the President's FY 2003 budget incorporates an increase to the TEFRA limit using 2.8 percent for the excluded hospital market basket increase.

Inpatient rehabilitation facilities (IRF) are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF PPS amount, updated annually.

Effective for cost reporting periods beginning on or after October 1, 2002, we are proposing that long-term care hospitals will be paid under a PPS based on a 5-year transition period (hospitals may elect to receive full PPS rather than transition payments.) For purposes of the update factor, the portion of the proposed PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long term care hospital's TEFRA limit by 2.8 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2003 budget. A final recommendation on the appropriate percentage increases for FY 2003 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC).

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2003.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,

Tommy G. Thompson

ATTACHMENT

Discussion of Two Market Basket Estimates

Section 1886(b)(3)(B)(iii) of the Act defines the "market basket percentage increase" as "the percentage, estimated by the Secretary" by which the cost of goods and services comprising inpatient hospital services "will exceed the cost of such goods and services for the preceding period. The estimate is based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services."

With the implementation of the Inpatient Prospective Payment System in Fiscal Year 1984, the Office of the Actuary (OACT) developed the market basket methodology and determined the official input price index from which the update percentage is calculated. OACT also forecasts the percentage increases for all of the Medicare payment categories that are updated by health-specific market baskets and other price indexes, including skilled nursing facility PPS, home health care PPS, and noninpatient hospital PPSs (capital, outpatient, rehabilitation facility, and hospice). To help ensure consistency among the many economic and price factors comprising the market baskets and other indexes, OACT contracts with a well-known and widely-respected independent forecasting firm, Global Insights/*DRI-WEFA*, to assist in making their forecasts.

In addition, each year for the President's Budget, the Office of Management and Budget forecasts the market basket by applying future assumptions of economy-wide wage and Consumer Price Index growth to the historical relationship between these factors and the market basket. This forecast does not attempt to capture the interrelationships among market basket factors that should be reflected in the actual update. OACT is in a stronger position to forecast the percentage increase in the market basket to be used in the actual update because they possess the detailed knowledge of the factors that affect the market basket, having developed these indexes for nearly two decades.

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

I. Background

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 inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this Appendix provides the recommendations of appropriate update factors and the analysis underlying our recommendations. We also respond to MedPAC's recommendations concerning the update factors.

Section 1886(b)(3)(B)(i)(XVIII) of the Act, as amended by Section 301 Public Law 106–554, sets the FY 2003 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.55 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2003 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 acute care hospital inpatient 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 2003 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system is the market basket percentage increase.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the proposed revised and rebased first quarter 2002 forecast of the FY 2003 market basket increase of 3.3 percent for hospitals subject to the acute care hospital inpatient prospective payment system, the proposed update to the standardized amounts is 2.75 percent (that is, the market basket rate of increase minus 0.55 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent.

Consistent with section 1886(e)(3) of the Act, we are proposing a recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from the hospital inpatient prospective payment system. Facilities excluded from the hospital inpatient prospective payment system include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, cancer hospitals, and children's hospitals.

In the past, hospitals and hospital units excluded from the hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316)).

Effective for cost reporting periods beginning during FY 2003, we are proposing that long-term care hospitals would be paid under a prospective payment system under which long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416)). We are also proposing that long-term care hospitals may elect to be paid on 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.4 percent).

In its March 1, 2002 Report to the Congress, MedPAC recommended that the base payment rates for Medicare covered services under the hospital inpatient prospective payment system be increased by the market basket percentage increase minus 0.55 percent for hospitals located in large urban areas, and by the full market basket percentage increase for hospitals located in all other areas (page 66). MedPAC did not make a separate recommendation for the hospital-specific rate applicable to SCHs and MDHs. MedPAC also presented a new approach for updating the hospital inpatient prospective system payment rates, which assesses the adequacy of current payments and accounts for the increase in efficient providers' costs in the upcoming year. While this approach is not fundamentally different from what MedPAC has done in the past, it no longer produces a detailed update framework for direct comparison with the Secretary's framework. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations in section III. of this Appendix C. Below we describe the basis of our FY 2003 update recommendation (as shown in Table 1).

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is the market basket percentage increase minus 0.55 percentage points for hospitals located in large urban and other areas. We are also recommending an update factor of the market basket percentage increase minus 0.55 percentage points for the hospital-specific rate for SCHs and MDHs. We believe these recommended update factors for FY 2003 would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

Rehabilitation hospitals and units are now paid under the IRF prospective payment system. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment system amount updated annually.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals be paid under a prospective payment system (67 FR 13416). For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services for FY 2003 would be determined by updating the TEFRA target amount for long-term care hospitals by the most recent available estimate of the increase in the excluded hospital operating market basket (or 3.4 percent).

We recommend that the remaining excluded hospitals and units (which are excluded from the acute care hospital inpatient prospective payment system and will continue to be paid on a reasonable cost basis in FY 2003) receive an update of 3.4 percent. The update for excluded hospitals and hospital units is equal to the most recent available estimate of the increase in the excluded hospital operating market basket. Based on the proposed revised and rebased first quarter 2002 forecast for FY 2003, the proposed market basket rate of increase for excluded hospitals and hospital units is 3.4 percent.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of MedPAC in setting these recommended update factors. Our responses to the MedPAC recommendations concerning the update factors are discussed below. Consistent with current law, we are proposing an update recommendation of the market basket percentage increase minus 0.55 percentage points for the hospital inpatient prospective payment system operating cost standardized amounts for FY 2003. This proposed update recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction.

A. Productivity

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

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through

1989 or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Absent a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.3 to 0.35 percent change in output per hour).

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

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected FY 2003 hospital output growth is simply the sum of the expected change in intensity (1.0 percent), projected admissions change (1.9 percent), and projected real case-mix growth (1.0 percent), or 3.9 percent. The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent (based on the proposed revised and rebased hospital market basket discussed in section IV. of the preamble of this proposed rule).

Multiplying the expected change in total hospital service output (3.9 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.6, provides our productivity standard of 0.9 to 0.7 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2003, we recommend an adjustment of 1.0 percent. The basis of this recommendation is discussed below.

Following methods developed by CMS' Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1997 through 2001 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Consumer Price Index (CPI) for hospital and related services and changes in real case-mix. [1] The 5-year average percentage change in charge per discharge was 6.3 percent, the 5-year average annual change in the CPI for hospital and related services was 4.5 percent, and the 5-year average annual change in case-mix was −0.3 percent. Dividing the change in charge per discharge by the product of the real case-mix index change and the CPI for hospital and related services yields a 5-year average annual change in intensity of 2.0 percent. To account for the proportions of the overall annual intensity increases due to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume that one-half of the annual increase is due to each of these factors. Our recommended adjustment excludes the estimated amount of the overall intensity increase due to ineffective practice patterns. Thus, we are recommending an intensity adjustment for FY 2003 of 1.0 percent.

C. Change in Case-Mix

Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2003 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs, but do not reflect greater resource requirements. We do not believe changes in coding behavior will impact the overall case-mix in FY 2003. As such, for FY 2003, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 percent adjustment for case-mix.

D. Effect of FY 2001 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2001 resulted in a 0.3 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. Therefore, we are recommending a −0.3 percent adjustment for the effect of FY 2001 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2001 payment rates was 3.4 percent. Our most recent data indicates the actual FY 2001 increase was 4.1 percent. The resulting forecast error in the FY 2001 market basket rate of increase is 0.7 percentage points. This forecast error is a result of prices for wages, benefits, and utilities increasing more rapidly than expected. The effects of a labor shortage within the health services industry caused hospitals to increase wages greater than initially projected. Increases in actual benefits were faster than projected due to a greater than expected increase in health insurance premiums. Finally, market conditions for natural gas and electricity caused

[1] In the past, we have considered the upper bound of real case mix to be from 1.0 to 1.4 percent annually, with any increase beyond this bound assumed to be due to changes in coding practices. Because none of the annual changes in observed case mix change during the 5-year period from FY 1997 through FY 2001 exceeded 1.0 percent, it is all assumed to be real case mix change.

prices for those products to increase more rapidly than expected.

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

HHS'S FY 2003 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustment Factors:	
Productivity	−0.9 to −0.7
Intensity	1.0
Subtotal	0.1 to 0.3
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0
Subtotal	0.0
Effect of FY 2001 DRG Reclassification and Recalibration	−0.3
Forecast Error Correction	0.7
Total Recommendation Update	MB + 0.5 to MB + 0.7

While the above analysis would suggest an update between market basket plus 0.5 percentage points and the market basket plus 0.7 percentage points, the Secretary is recommending, consistent with current law, an update of the market basket percentage increase minus 0.55 percentage points (or 2.75 percent) for hospitals in all areas.

We believe that a 2.75 percent update factor for FY 2003 will appropriately reflect current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Also, consistent with current law, we are recommending that the hospital-specific rates applicable to SCHs and MDHs be increased by the same update, 2.75 percentage points.

Since the inception of the acute care hospital inpatient prospective payment system, hospitals have received a full market basket update only once, in FY 2001. The stabilization of overall hospital margins in recent years suggests that the restrictions on market basket increases have not resulted in inadequate hospital payments. Modest limits below full market basket updates could be linked to continued careful review of Medicare hospital margin data to ensure that margins do not worsen among certain hospital types with negative and declining Medicare margins.

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

In its FY 2002 Report to Congress, MedPAC developed a new approach for updating fee-for-service payments that breaks the process into two basic parts: assessing the adequacy of current payments; and accounting for the increase in efficient providers' costs in the coming year. MedPAC points out this new approach ''is not fundamentally different from what the Commission has done in the past, but we expect formalizing the two parts of our process will lead to greater emphasis on the broad question of whether the amount of money in the system currently is right and less emphasis on the role of specific cost-influencing factors'' (page 39).

In assessing payment adequacy, MedPAC reviews the relationship between costs and payments (conventionally expressed as a margin). On the payment side, MedPAC applied the annual payment updates specified in law through FY 2002 and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in costs per unit of output over the same period using the change in cost per adjusted admission in the American Hospital Association's annual survey of hospitals for FY 2000, and the CMS projected increase in the FYs 2001 and 2002 market baskets (page 58). MedPAC estimated that the inpatient Medicare margin would be 10.8 percent in FY 2002 (with FY 2003 payment rules). This amount is down slightly from MedPAC's estimate of 11.9 percent in FY 1999. In addition to the inpatient Medicare margin, MedPAC measured the overall Medicare margin, incorporating almost all Medicare-related payments and costs to hospitals. This overall Medicare margin was estimated to be 3.8 percent. The report notes that ''the Commission does not plan to specify a 'standard margin,' although we will take the need for a small positive margin into account as we assess the adequacy of various fee-for-service payments'' (page 43).

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate (page 43):

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

MedPAC found no evidence that the hospital cost base is inappropriate and concluded that Medicare payment is adequate and no payment adequacy adjustment is needed for FY 2003.

MedPAC recommends gradually eliminating the differential in the standardized amounts for hospitals in large urban and other areas. MedPAC's data on margins and its analysis of costs suggest that a different standardized amount (the large urban standardized amount is 1.6 percent higher than the amount for other areas) is unwarranted. MedPAC estimates the FY 2002 Medicare inpatient margins will range from 5 percent for rural hospitals to 14 percent for hospitals in large urban areas. Because much of this difference is due to the greater proportion of IME and DSH payments going to hospitals in large urban areas, MedPAC removed DSH payments and the portion of the IME payment above the measured cost relationship between IME and hospitals' costs, and found that hospitals in large urban areas still have Medicare margins that are about 4 percentage points higher than other urban and rural hospitals (page 64).

MedPAC believes that ''(e)liminating the differential would improve payment equity across geographic areas and also help to simplify the payment system'' (page 63). For example, eliminating the standardized amount differential would also eliminate the need for hospitals to reclassify for a higher standardized amount through the MGCRB. Therefore, MedPAC recommends holding the update for hospitals in large urban areas to the legislated level of the market

basket percentage increase minus 0.55 percent for FY 2003, while updating the other areas standardized amount by the full market basket percentage increase.

MedPAC accounts for providers' cost changes in the coming payment year primarily through a forecast of input price inflation, which estimates how much providers' costs would rise in the coming year if the quality and mix of inputs they use to furnish care and the types of patients they treat remain constant. MedPAC relies on CMS' market basket estimate to forecast input price inflation, but considers other factors that may affect providers' costs. These other factors are scientific and technological advances, changes in DRG case-mix complexity, site-of-service substitution, and other one-time factors.

In the past, MedPAC recommended specific adjustments to its update recommendation for each of these factors. In its March 2002 Report to Congress, MedPAC did not provide specific estimates for these factors, but stated ''(a)fter considering all factors that might potentially affect the rate of growth in efficient providers' costs, we conclude that the appropriate adjustment for cost growth in fiscal year 2003 is the forecasted increase in the market basket, or 2.9 percent'' (page 66). This market basket forecast was based on the December 2001 market basket estimated by CMS' Office of the Actuary, and does not reflect the proposed revisions and rebasing discussed in section IV. of the preamble of this proposed rule.

MedPAC's second recommendation related to updating payments under the hospital inpatient prospective payment system is that the Congress should increase the base rate for inpatient services covered by Medicare's prospective payment system in FY 2003 by the market basket percentage increase minus 0.55 percent for hospitals in large urban areas and by the market basket percentage increase for hospitals in all other areas. MedPAC focused on the operating update only because it applies to 92 percent of hospitals' Medicare costs. The report noted that, in its March 2000 report to Congress, MedPAC recommended combining the operating and capital payment systems into a single prospective payment system.

Response: As described above, we continue to use our detailed update framework to develop our recommended update for FY 2003. However, we believe MedPAC's new approach will be useful to focusing the policy discussion more directly on the overall adequacy of hospital payments. We look forward to continuing to work with MedPAC to refine and utilize both methodologies in an effort to produce analyses that provide the most helpful information for setting the annual updates.

We agree with MedPAC's recommendation that the current law update for FY 2003 of the market basket percentage increase minus 0.55 percentage points is appropriate for the operating system update. However, we are not recommending differential updates to gradually eliminate the higher standardized amount for hospitals in large urban areas, as recommended by MedPAC. We believe the stabilization of overall hospital margins in recent years suggests that modest limits below full market basket updates provide adequate payments. We agree, however, that certain hospital types that show clear evidence of negative and declining Medicare margins should be monitored closely.

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

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