

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, and 485

[CMS-1203-CN]

RIN 0938-AL23

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

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

ACTION: Correction of final rule.

SUMMARY: This document corrects technical errors that appeared in the final rule published in the *Federal Register* on August 1, 2002 entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates," including three technical errors in the wage index values. Except for the three wage index corrections, these technical corrections are effective retroactively to October 1, 2002. The corrections to the wage index values are effective prospectively for discharges occurring on or after April 28, 2003.

EFFECTIVE DATES: All corrections except those listed in items 12(b) and 13 of section III of this notice are effective as of October 1, 2002. The corrections listed in items 12(b) and 13 of section III of this document are effective on April 28, 2003.

FOR FURTHER INFORMATION CONTACT: Margot Blige Holloway, (410) 786-4642.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 02-19292 of August 1, 2002 (67 FR 49982), there were a number of technical errors that are identified and corrected in the Correction of Errors section below. With the exception of three provisions related to correction of wage index values, the provisions in this correction notice are effective as if they had been included in the document published on August 1, 2002. Accordingly, these corrections are effective on October 1, 2002. The three corrected wage index values are effective prospectively with discharges occurring on or after April 28, 2003. The errors in these wage index values resulted from the inadvertent use of incorrect geographic reclassification designations or wage data or both in calculating these values.

II. Summary of the Corrections to the August 1, 2002 Final Rule

This correction notice makes a number of changes to the August 1, 2002 final rule. Because of the number of corrections and length of some of these corrections, we are summarizing the corrections in sections II.A. and II.B. of the notice. Sections II.A. and II.B. of the notice describe the corrections that are effective October 1, 2002 and April 28, 2003, respectively. Section III of this notice specifies the details of each correction to the August 1, 2002 final rule.

A. Corrections Effective October 1, 2002

In section II.B.2.b of the final rule, we described the revisions to diagnostic related groups (DRGs) 14 and 15. Beginning on page 49988 of the final rule, we presented the public comments and our responses to the proposed changes to these DRGs. However, we inadvertently omitted two comments regarding the proposed changes to DRGs 14 and 15. We apologize for this omission, as we fully intend to monitor these DRGs and the cases assigned to them. In addition, we discovered, and are correcting, typographical errors on pages 49994 and 50005.

On page 50014 of the final rule, we discussed the new technology application for Xigris™. In our discussion of our decision to approve the application to receive new technology add-on payments, we mistakenly listed the following criteria for use as "FDA-listed indications and contraindications":

- Active internal bleeding;
- Recent (within 3 months) hemorrhagic stroke;
- Recent (within 2 months) intracranial or intraspinal surgery or severe head trauma;
- Trauma with an increase risk of life-threatening bleeding;
- Presence of an epidural catheter;
- Intracranial neoplasm or mass lesion or evidence of cerebral herniation.

We are correcting this error in section III of this notice and make note that the items in the list above are the FDA-labeled contraindications to the use of this drug. The FDA approval of Xigris™ also specified that its use 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." In the study supporting the FDA approval of this drug risk of death was determined by the patient's Acute Physiology and Chronic Health Evaluation (APACHE II) score, which is

commonly used in intensive care units to make this judgment. Patients with APACHE II scores of less than 25 were at a lower risk of death and had no advantage in mortality from the use of Xigris™.

On page 50053 of the final rule, we discussed the amendment to the definition of "like hospital," which is used for purposes of determining sole community hospital (SCH) status. The amended definition of "like hospital" excludes any hospital that provides 8 percent or less of the services furnished by the SCH. We also adopted inpatient days as the unit of measurement, as a proxy for measuring services. In the preamble discussion, there were references both to using Medicare inpatient days and total inpatient days as a proxy for measuring service overlap. It is total inpatient days, not Medicare inpatient days, that will be used as a proxy to measure service overlap. Accordingly, we are correcting the references regarding inpatient days and patient days that appeared on pages 50054 through 50056 of the final rule. However, we note that the revision to the regulations at § 412.92(c)(2) correctly reflects total inpatient days as the proxy for measuring service overlap.

On page 50126 we are correcting a typographical error in the budget neutrality factor. Therefore, the figure "0.994027" will be corrected to read "0.993209".

On September 30, 2002, we published a program memorandum, Transmittal A-02-092, to correct certain wage index values and hospital geographical classifications that we published incorrectly in the August 1, 2001 and August 1, 2002 final rules. The corrections were made to errors by CMS and the fiscal intermediaries in handling the data used to calculate certain average hourly wages, wage indexes, and capital geographic adjustment factors (GAFs) published in tables 2, 3A, 4A, and 9. (The corrections are to items referenced on pages 50155, 50199, 50212, and 50217).

On pages 50223 through 50229 of the August 1, 2002 final rule, we published tables 4G and 4H. There are errors in the wage indexes listed in these tables as a result of the use of an incorrect data file. These changes are not retroactive decisions, but simply constitute corrections resulting from the mishandling of data. In section III of this notice, we will republish tables 4G and 4H to correct the errors made in the wage index values listed in those tables.

On pages 50230 through 50239, we published table 5. This table contained several typographical errors (on pages 50236 and 50238, respectively) that we

will correct in section III of this notice. These changes are not retroactive decisions, but simply constitute corrections to typographical errors in the table.

On pages 50264 through 50273, we published table 9. There are errors in several of the entries of the table and we are correcting these errors by identifying entries that should be deleted, added, or revised. These errors were brought to our attention after the publication of the August 1, 2002 final rule. The corrections to hospitals' reclassification status are effective with discharges occurring on or after October 1, 2002. These corrections make table 9 consistent with the hospitals' actual payment designations. Therefore, they are not retroactive decisions, but simply constitute corrections to typographical errors in the table. The corrections to table 9 are specified in section III of this notice.

Appendix A—Regulatory Impact Analysis (pages 50276 through 50288) provides a detailed analysis of the impact of the final rule on hospitals included and excluded from the acute care hospital inpatient prospective payment systems. We note that there are technical and typographical errors in some of the explanatory language and the tables in sections I through VIII of the appendix, pages 50276 through 50285. These technical errors do not affect payment amounts or payment methodology. Therefore, they are not retroactive decisions, but simply constitute corrections to technical and typographical errors in the impact analysis section of the final rule. Because of the number of changes to this section, we are correcting the errors by reprinting the sections with the corrected text and providing the following list of corrections:

- On page 50276, the revisions are as follows:

- Second column, first paragraph, 13th and 14th lines, the phrase “\$0.3 billion increase” will be corrected to read “\$300 million increase”;
- Second column, third full paragraph, 4th and 5th lines, the phrase “and the effects on some may be significant” will be corrected to read “and that the effects on some hospitals may be significant”;
- Second column, fourth full paragraph, 9th through 11th lines, the phrase “mandate any requirements for State, local, or tribal governments” will be corrected to read “result in any unfunded mandates for State, local, or tribal governments or the private sector as defined by section 202”;
- Third column, second full paragraph, 6th through 9th lines, the phrase “to

adequately compensate hospitals for their legitimate costs” will be corrected to read “to compensate hospitals adequately for their legitimate costs”;

- Third column, second full paragraph, 9th line, the phrase “we share national goals” will be corrected to read “we share the national goal”;
- Third column, fourth full paragraph, 14th line, the phrase “proposed rules, we solicited comments and” will be corrected to read “proposed rules, in the May 9, 2002 proposed rule, we solicited comments and”;
- Third column, seventh full paragraph, 4th through 7th lines, the sentence “We did include overall savings estimates attributable to the provision in the preamble discussion.” will be corrected to read “We did consider overall savings estimates attributable to the provision in the preamble discussion. Furthermore, we have not provided such an analysis in the impact tables in this final rule because we have decided not to make revisions to the postacute care transfer policy at this time. As stated elsewhere in the preamble, we will continue to assess whether further expansions or refinements of the transfer policy may be warranted for FY 2004 or subsequent years, and, if so, how to design such refinements and assess their impact.”;

- On page 50277, the revisions are as follows:

- First column, first paragraph, 11th through 12th lines, the phrase “of the beneficiary and make more decisions based on solvency” will be corrected to read “on the needs of the beneficiary and force them to make more decisions based on solvency”;
- First column, first full paragraph, 6th through 9th lines, the phrase “high outlier payments hospitals are receiving in FY 2002 (approximately 7.2 percent of total DRG payments) compared to the FY 2003 estimated 5.1 percent” will be corrected to read “high total of outlier payments hospitals are receiving in FY 2002 (approximately 6.9 percent of total DRG payments) compared to the FY 2003 estimate of 5.1 percent”;
- First column, second full paragraph, 9th line, the phrase “the prospective payment method” will be corrected to read “the prospective payment methodology”;
- First column, the last paragraph, will be corrected to read as specified in section III of this notice.
- Third column, first full paragraph, 7th and 8th lines, the phrase “\$0.3 billion” will be corrected to read “\$300 million”;

- Third column, second full paragraph, 3rd line from the bottom, the phrase “available source overall” will be corrected to read “available data overall”;

- On page 50278 the revisions are as follows:

- First column, second full paragraph, 4th line, the phrase “This allows” will be corrected to read “This methodology allows”;
- First column, third full paragraph, last 3 lines, the phrase “(MDHs) is also equal to the market basket increase of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent).” will be corrected to read “(MDHs) are also equal to the market basket increase of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent). We estimate the aggregate impact of this update will be to increase hospital payments by \$500 million.”;
- First column, fourth full paragraph, 2nd line, the phrase “changes in hospitals” will be corrected to read “changes in a hospital’s”;
- First column, fourth full paragraph, last line, the line will be corrected by adding the following sentence “Because the impact of MGCRB reclassifications are budget neutral overall, the only impacts of these changes are on payments to individual hospitals and hospital groups.”
- First column, last paragraph, 3rd line, the figure “7.2” will be corrected to read “6.9”.
- Second column, first paragraph, last line, the line will be corrected by adding the following sentence “We estimate FY 2002 payments will be approximately \$1.5 billion higher than if outlier payments had been 5.1 percent of total DRG payments.”
- Second column, second full paragraph, last line, the line will be corrected by adding the following sentence “We estimate the impact of this reduction will be to decrease aggregate payments by \$1 billion.”
- Second column, seventh full paragraph, last line, the line will be corrected by adding the following sentence “We estimate the higher DSH payments will increase overall Medicare payments to hospitals by \$200 million.”
- On pages 50279 through 50280, Table I—Impact Analysis of Changes for FY 2003, Operating Prospective Payment System, we are correcting the numbering of the columns and some of the figures contained with the table. The corrected table is in section III of this notice.

• On pages 50281 through 50283, we provide a detailed explanation of impact of the changes displayed in Table I. This explanation includes references to column numbers and to figures contained in Table I. We are correcting the numbering of the columns and some of the figures in the table; therefore, we will also correct these figures in our explanation of Table I. We also note the following corrections:

- On page 50281,
 - Third column, first full paragraph, line 9, the phrase “80 percent with” will be corrected to read “80 percent of”;
 - Third column, last paragraph, lines 8 and 9, the figures “(343)” and “11” will be corrected to read “(344)” and “10” respectively;
 - Chart showing the “percentage change in area wage index values”, third column of the chart, the figures “11” and “343” will be corrected to read “10” and “344” respectively;
 - Third column, last paragraph, last two lines, the phrase “greater than 5 percent or with increases of more than 10 percent” will be corrected to read “greater than 5 percent but less than 10 percent. There are no rural hospitals with decreases in their wage index value greater than 10 percent.”;
- On page 50282,
 - Chart at the top of the page, the figures “2553” and “1975” will be corrected to read “2565” and “1985” respectively;
 - Second column, second full paragraph, lines 1 through 3, the sentence “The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral.” will be corrected to read “Section 1886(d)(8)(D) of the Act requires that the overall effect of geographic reclassification is budget neutral.”
 - Second column, second full paragraph, line 5, the figure “0.990672” will be corrected to read “0.991095”;
 - Second column, fourth full paragraph, lines 1 and 2, the sentence “A positive impact is evident among of the most rural hospital groups.” will be corrected to read “Geographic reclassification has a positive impact on most of the rural hospital groups.”;
 - Second column, last paragraph, lines 9 and 10, the phrase “while rural reclassified hospitals are expected” will be corrected to read “while rural reclassified hospitals are also expected”;
 - Third column, first full paragraph, line 3, the phrase “in this proposed rule” will be corrected to read “in this final rule”;

- Third column, first full paragraph, lines 6 and 7, the phrase “policy changes to date” will be corrected to read “policy changes”;
- Third column, second full paragraph, line 1, the phrase “It includes” will be corrected to read “Column 7 includes”;
- Third column, second full paragraph, line 9, the figure “7.2” will be corrected to read “6.9”.
 - On page 50283,
 - First column, third paragraph, lines 5 and 6, the phrase “Hospitals in rural areas, meanwhile, experience” will be corrected to read “Meanwhile, hospitals in rural areas experience”;
 - Second column, first full paragraph—
 - ++ Line 7, the phrase “This is primarily due” will be corrected to read “These reductions are primarily due”;
 - ++ Line 11, the phrase “only hospital category” will be corrected to read “only rural hospital category”;
 - ++ Line 14, the phrase “updated wage data” will be corrected to read “updated wage index data”;
 - ++ Line 14, the phrase “In the East” will be corrected to read “In the rural East”;
 - ++ Line 16, the phrase “Mountain and West” will be corrected to read “The rural Mountain and West”;
 - Third column, first full paragraph, line 2, the phrase “receive a” will be corrected to read “receive an overall”;
 - On pages 50283 through 50284, Table II—Impact Analysis of Changes for FY 2003 Operating Prospective Payment System, the table will be corrected to read as specified in section III of this notice.
 - On page 50285—
 - First column, first paragraph, last line, the phrase “from column 8 of Table I will be corrected to read “from column 7 of Table I”;
 - First column, second full paragraph, the section entitled VII.A. Impact of Changes Relating to Payment for the Clinical Training Portion of Clinical Psychology Training Programs was inadvertently included in the final rule. Therefore, we are correcting this error by deleting the text of this section and renumbering sections VII.B. and VII.C. as sections VII.A. and VII.B. respectively. We are also making revisions to the heading of renumbered section VII.A. and to the discussions in the both of sections. Please see section III of this notice for the revised language;
 - Second column, second paragraph, lines 7 through 9, the sentence “Currently, we have identified 622 hospitals that qualify under this provision” will be corrected to read

- “We have identified 622 hospitals that currently qualify under this provision”.
- Second column, third paragraph—
 - ++ Line 5, the phrase “appear to receive this adjustment” will be corrected to read “will receive pass-through payments”;
 - ++ Lines 5 through 8, the sentence “In order to be eligible, hospitals must employ the CRNA and the CRNA must agree not to bill for services under Part B.” will be corrected to read “That is, another approximately 600 rural hospitals have similar volumes to hospitals that currently receive the pass-through. However, because in order to be eligible to receive pass-through payments, the hospital must employ the CRNA and the CRNA must agree not to bill for services under Part B, we estimate that half the hospitals that would otherwise qualify based on volume of procedures are not eligible because they either do not employ the CRNA or the CRNA does not agree not to bill for services under Part B.”;
 - ++ Lines 11 through 15, the sentence “If one-half of these hospitals then met the other criteria, 45 additional hospitals would be eligible for these pass-through payments under this change” will be corrected to read “If one-half of these hospitals then met the other criteria (the CRNA is employed by the hospital and the CRNA does not bill for Part B), 45 additional hospitals would now be eligible for these pass-through payments under this change.”;
- Second column, fourth paragraph—
 - ++ Line 5, the figure “600” will be corrected to read “630”;
 - ++ Line 7, the figure “270” will be corrected to read “598”.
- Second column, after the fourth paragraph, we are adding a new section C to read as specified in section III of this notice.

B. Corrections Effective April 28, 2003

This section summarizes three wage index corrections that result from our errors in the geographic reclassification designations and wage data that were used to calculate the FY 2003 wage indexes for three hospitals. Where errors are identified and corrections are made to the wage index, we believe it is appropriate to apply the revised wage index prospectively. As we stated in the January 3, 1984 final rule (49 FR 258), “Application of a retroactive adjustment to the rates [for corrections in the wage index] would erode the basis of the prospective payment system that payment will be made at a predetermined, specified rate.” Because we can only make prospective changes

to the wage index values, these corrections are effective for discharges occurring on or after April 28, 2003.

On pages 50214 through 50221 of the August 1, 2002 final rule, we published table 4A. In addition, on pages 50221 through 50223, we published table 4C. These tables contain errors as a result of errors in the geographic reclassification designations or the wage data or both used to calculate the hospitals' wage index values. Items 12(b) and 13 of section III of this notice specify these corrections.

III. Correction of Errors

In FR Doc. 02-19292 of August 1, 2002 (67 FR 49982), make the following corrections:

1. On page 49989, in the first column, before the first full paragraph the following paragraphs are inserted:

Comment: One commenter is opposed to the reassignment of code 436 from DRG 14 to DRG 15, citing that this will create a need for additional government oversight due to an increase in adverse coding compliance issues. The commenter is concerned that if code 436 is moved from the higher weighted DRG, coders may increase the use of the physician query process in an effort to obtain the higher-weighted DRG 14. The commenter states that CMS has previously expressed concerns regarding the physician query process, and the reassignment of this code may exacerbate the problem of "leading" physician queries. The commenter goes on to state that the Office of Inspector General (OIG) has previously identified DRG pair 14 and 15 as deserving of scrutiny for potential fraud and abuse issues, and that the movement of code 436 may also result in escalated monitoring.

Response: It is possible that this change will result in the need for additional government oversight due to an increase in adverse coding compliance issues. If a physician is not able to more specifically label a patient's stroke as hemorrhagic or occlusive and instead documents cerebrovascular accident (CVA), the expected code would be 436. Cases where the documentation supports code 436, but another code is present on the medical record, may be subject to additional scrutiny.

Comment: A commenter has stated that placement of code 436 in DRG 15 instead of the higher weighted DRG 14 places an unfair and adverse financial burden on struggling rural health care providers. The commenter notes that in facilities without computerized tomography (CT) or magnetic resonance imaging (MRI) scanning technology,

physicians may be unwilling to document infarction or hemorrhage without confirming imaging studies. The commenter also notes that correct coding of lacunar infarction will result in DRG 14, when in fact a lacunar infarction may cause a sudden but often only minimal residual deficit, while a CVA could have much more severe residual deficits.

Response: We have placed code 436 in DRG 15 strictly on the basis of historical hospital charge data, not with any punitive intent. We understand that strokes vary in the nature and intensity of their residual deficits. We also understand that very specific diagnostic tests or radiology examinations may be outside the scope of the treating facility and that physicians may opt to treat an obvious stroke patient without performing additional extensive studies that drive up the cost of medical care. We will continue to monitor the use of code 436, and will reexamine its DRG placement during the next fiscal year."

2. On page 49994, in the second column, first full paragraph, fourth line, the figure "87.06" is corrected to read "86.07".

3. On page 50005, second column, lines 12 through 14, the phrase "The principal diagnosis will consist of any principal diagnosis in MDC 5 except AMI:" is corrected to read "New DRG 527 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI) will have a principal diagnosis of any principal diagnosis in MDC5 except AMI:".

4. On page 50014, first column, last paragraph, the paragraph is corrected to read as follows:

"Xigris™ was found to carry an increased risk of bleeding and for this reason the FDA listed the following contradictions to Xigris™ use on the approved label:

- Active internal bleeding;
- Recent (within 3 months) hemorrhagic stroke;
- Recent (within 2 months) intracranial or intraspinal surgery or severe head trauma;
- Trauma with an increased risk of life-threatening bleeding;
- Presence of an epidural catheter; and
- Intracranial neoplasm or mass lesion or evidence of cerebral herniation.

In addition, patients with an APACHE II score of less than 25 were at lower risk of death and had no advantage in mortality from the use of Xigris™."

5. On page 50054,

a. First column, fourth full paragraph, lines 1 and 2, the phrase "Medicare

inpatient days" is corrected to read "total inpatient days";

b. Second column, second full paragraph, lines 20 and 21, the phrase "inpatient days" is corrected to read "total inpatient days".

6. On page 50055,

a. First column, third full paragraph, line 12, the phrase "inpatient days" is corrected to read "total inpatient days";

b. First column, third full paragraph, line 23, the phrase "The number of inpatient days" is corrected to read "The total number of inpatient days";

c. First column, last paragraph, lines 1 and 2, the phrase "Medicare inpatient days" is corrected to read "total inpatient days";

d. Second column, fourth full paragraph, line 13, the phrase "inpatient days" is corrected to read "total inpatient days".

7. On page 50056, first column, first partial paragraph, line 2, the phrase "number of patient days" is corrected to read "total number of inpatient days".

8. On page 50126, third column, third paragraph, line 16, the figure "0.994027" is corrected to read "0.993209".

9. On page 50155, in 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, line 12 (provider no. 140155),

a. Fourth column, the figure "13.0438" is corrected to read "24.2907";

b. Fifth column, the figure "17.2026" is corrected to read "21.4743";

10. On page 50199, in 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, line 22 (provider no. 450054),

a. Fourth column, the figure "23.0492" is corrected to read "25.3285";

b. Fifth column, the figure "21.9091" is corrected to read "22.6900";

11. On page 50212, in Table 3A—FY 2003 and 3-Year Average Hourly Wage for Urban Areas, second set of columns,

a. Line 40 (Kankakee, IL), (1) Second column, the figure "18.8681" is corrected to read "25.0641"

(2) Third column, the figure "20.7325" is corrected to read "22.8591"

b. Line 43 (Killeen-Temple, TX), (1) Second column, the figure "22.2296" is corrected to read "24.1567"

(2) Third column, the figure "21.1752" is corrected to read "21.8355".

12. On pages 50214 through 50221, in Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas,

a. On page 50217, second set of columns,

(1) Line 26 (3740 Kankakee, IL),

(a) Second column, the figure "0.8204" is corrected to read "1.0790";

(b) Third column, the figure "0.8732" is corrected to read "1.0534".

(2) Line 43 (3810 Killeen-Temple, TX),

(a) Second column, the figure "0.9570" is corrected to read "1.0399";

(b) Third column, the figure "0.9704" is corrected to read "1.0272".

b. On page 50219,

(1) First set of columns, line 52 (6340 Pocatello, ID),

(a) Second column, the figure "0.9674" is corrected to read "0.9372";

(b) Third column, the figure "0.9776" is corrected to read "0.9566".

(2) Second set of columns, line 14 (6520 Provo-Orem, UT),

(a) Second column, the figure "0.9984" is corrected to read "0.9879";

(b) Third column, the figure "0.9989" is corrected to read "0.9917".

13. On page 50222, in Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified,

a. First set of columns, line 56 (Huntsville, AL)

(1) Second column, the figure "0.8771" is corrected to read "0.8789";

(2) Third column, the figure "0.9141" is corrected to read "0.9154".

b. Third set of columns,

(1) Line 4 (Pocatello, ID),

(a) Second column, the figure "0.9674" is corrected to read "0.9175";

(b) Third column, the figure "0.9776" is corrected to read "0.9427".

(2) Line 8 (Provo-Orem, UT),

(a) Second column, the figure "0.9984" is corrected to read "0.9879";

(b) Third column, the figure "0.9989" is corrected to read "0.9917".

14. On pages 50223 through 50229, in Table 4G, Pre-Reclassified Wage Index for Urban Areas, the table is corrected to read as follows:

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX
Taylor, TX	
0060 Aguadilla, PR	0.4587
Aguada, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9600
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0594
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8542
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9315
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7859
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9735
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9225
Blair, PA	
0320 Amarillo, TX	0.9034
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2358
Anchorage, AK	
0440 Ann Arbor, MI	1.1103
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8044
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9162
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4356
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9876
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0211
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	0.9991
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	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1017
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8325
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0264
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9637
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9899
Kern, CA	
0720 Baltimore, MD	0.9929
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9664
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	
Barnstable, MA	
0760 Baton Rouge, LA	0.8294
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX ..	0.8324
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2282
Whatcom, WA	
0870 Benton Harbor, MI	0.9042
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2150
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9022
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8757
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8542
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9222
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7972

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Burleigh, ND Morton, ND	
1020 Bloomington, IN	0.8907
Monroe, IN	
1040 Bloomington-Normal, IL	0.9109
McLean, IL	
1080 Boise City, ID	0.9310
Ada, ID Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1288
Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	
1125 BoulderLongmont, CO	0.9689
Boulder, CO	
1145 Brazoria, TX	0.8535
Brazoria, TX	
1150 Bremerton, WA	1.0944
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8880
Cameron, TX	
1260 Bryan-College Station, TX ..	0.8821
Brazos, TX	
1280 Buffalo-Niagara Falls, NY ...	0.9365
Erie, NY Niagara, NY	
1303 Burlington, VT	1.0052
Chittenden, VT Franklin, VT Grand Isle, VT	
1310 Caguas, PR	0.4371
Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8932
Carroll, OH Stark, OH	
1350 Casper, WY	0.9690
Natrona, WY	
1360 Cedar Rapids, IA	0.9056
Linn, IA	
1400 Champaign-Urbana, IL	1.0635
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9235
Berkeley, SC Charleston, SC Dorchester, SC	
1480 Charleston, WV	0.8898
Kanawha, WV Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9850
Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rowan, NC Stanly, NC Union, NC York, SC	
1540 Charlottesville, VA	1.0438
Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	
1560 Chattanooga, TN-GA	0.8976
Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	
1580 Cheyenne, WY	0.9007
Laramie, WY	
1600 Chicago, IL	1.1044
Cook, IL DeKalb, IL DuPage, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	
1620 Chico-Paradise, CA	0.9840
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9381
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	0.8406
Christian, KY Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9670
Ashtabula, OH Cuyahoga, OH Geauga, OH Lake, OH Lorain, OH Medina, OH	
1720 Colorado Springs, CO	0.9916
El Paso, CO	
1740 Columbia, MO	0.8496
Boone, MO	
1760 Columbia, SC	0.9307
Lexington, SC Richland, SC	
1800 Columbus, GA-AL	0.8374
Russell, AL Chattahoochee, GA Harris, GA Muscogee, GA	
1840 Columbus, OH	0.9751
Delaware, OH Fairfield, OH Franklin, OH Licking, OH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Madison, OH Pickaway, OH	
1880 Corpus Christi, TX	0.8729
Nueces, TX San Patricio, TX	
1890 Corvallis, OR	1.1453
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.7975
Allegany, MD Mineral, WV	
1920 Dallas, TX	0.9998
Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	
1950 Danville, VA	0.8859
Danville City, VA Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8835
Scott, IA Henry, IL Rock Island, IL	
2000 Dayton-Springfield, OH	0.9282
Clark, OH Greene, OH Miami, OH Montgomery, OH	
2020 Daytona Beach, FL	0.9062
Flagler, FL Volusia, FL	
2030 Decatur, AL	0.8973
Lawrence, AL Morgan, AL	
2040 Decatur, IL	0.8204
Macon, IL	
2080 Denver, CO	1.0601
Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	
2120 Des Moines, IA	0.8791
Dallas, IA Polk, IA Warren, IA	
2160 Detroit, MI	1.0448
Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	
2180 Dothan, AL	0.8137
Dale, AL Houston, AL	
2190 Dover, DE	0.9356
Kent, DE	
2200 Dubuque, IA	0.8795
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0368
St. Louis, MN Douglas, WI	
2281 Dutchess County, NY	1.0684
Dutchess, NY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
2290 Eau Claire, WI	0.9162
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9265
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9722
Elkhart, IN	
2335 Elmira, NY	0.8542
Chemung, NY	
2340 Enid, OK	0.8376
Garfield, OK	
2360 Erie, PA	0.8925
Erie, PA	
2400 Eugene-Springfield, OR	1.0944
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8755
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN ...	0.9684
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8889
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8100
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0682
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1135
Genesee, MI	
2650 Florence, AL	0.7792
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8780
Florence, SC	
2670 Fort Collins-Loveland, CO ..	1.0066
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0297
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9680
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9823
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7895
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9693
Okaloosa, FL	
2760 Fort Wayne, IN	0.9457
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX ...	0.9446
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0216
Fresno, CA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Madera, CA	
2880 Gadsden, AL	0.8505
Etowah, AL	
2900 Gainesville, FL	0.9871
Alachua, FL	
2920 Galveston-Texas City, TX ...	0.9465
Galveston, TX	
2960 Gary, IN	0.9584
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8542
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8892
Wayne, NC	
2985 Grand Forks, ND-MN	0.8897
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9456
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	0.9525
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8950
Cascade, MT	
3060 Greeley, CO	0.9237
Weld, CO	
3080 Green Bay, WI	0.9502
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9282
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9100
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9122
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9268
Washington, MD	
3200 Hamilton-Middletown, OH ...	0.9418
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9223
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2394
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
³ 285 ² Hattiesburg, MS	0.7680
Forrest, MS	
Lamar, MS	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
3290 Hickory-Morganton-Lenoir, NC	0.9028
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1457
Honolulu, HI	
3350 Houma, LA	0.8385
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9892
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9636
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8903
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9717
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9587
Johnson, IA	
3520 Jackson, MI	0.9532
Jackson, MI	
3560 Jackson, MS	0.8607
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9275
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9381
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8666
Onslow, NC	
3610 Jamestown, NY	0.8542
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9849
Rock, WI	
3640 Jersey City, NJ	1.1190
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8268
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8462
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7749
Craighead, AR	
3710 Joplin, MO	0.8613
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0595
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.0790
Kankakee, IL	
3760 Kansas City, KS-MO	0.9736
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	0.9686
Kenosha, WI	
3810 Killeen-Temple, TX	1.0399
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8970
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8971
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9400
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8475
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9278
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7965
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9357
Polk, FL	
4000 Lancaster, PA	0.9078
Lancaster, PA	
4040 Lansing-East Lansing, MI ...	0.9726
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8472
Webb, TX	
4100 Las Cruces, NM	0.8872
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1521

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7923
Douglas, KS	
4200 Lawton, OK	0.8315
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9179
Androscoggin, ME	
4280 Lexington, KY	0.8581
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9892
Lancaster, NE	
4400 Little Rock-North Little	
Rock, AR	0.9097
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8629
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach,	
CA	1.2001
Los Angeles, CA	
4520 ¹ Louisville, KY-IN	0.9276
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.9646
Lubbock, TX	
4640 Lynchburg, VA	0.9219
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9204
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0467
Dane, WI	
4800 Mansfield, OH	0.8900
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4914
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
4880 McAllen-Edinburg-Mission,	
TX	0.8428
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0498
Jackson, OR	
4900 Melbourne-Titusville-Palm	
Bay, FL	1.0253
Brevard, FL	
4920 Memphis, TN-AR-MS	0.8920
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9840
Merced, CA	
5000 Miami, FL	0.9802
Dade, FL	
5015 Middlesex-Somerset-	
Hunterdon, NJ	1.1213
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI ..	0.9893
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-	
WI	1.0903
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	0.9157
Missoula, MT	
5160 Mobile, AL	0.8108
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0498
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0674
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8137
Ouachita, LA	
5240 Montgomery, AL	0.7734
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9284
Delaware, IN	
5330 Myrtle Beach, SC	0.8976
Horry, SC	
5345 Naples, FL	0.9754
Collier, FL	
5360 Nashville, TN	0.9578
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rutherford TN Sumner, TN Williamson, TN Wilson, TN	
5380 Nassau-Suffolk, NY	1.3357
Nassau, NY Suffolk, NY	
5483 New Haven-Bridgeport- Stamford-Waterbury-Danbury, CT	1.2408
Fairfield, CT New Haven, CT	
5523 New London-Norwich, CT New London, CT	1.2394
5560 New Orleans, LA	0.9046
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	1.4414
Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	
5640 Newark, NJ	1.1381
Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	
5660 Newburgh, NY-PA	1.1387
Orange, NY Pike, PA	
5720 Norfolk-Virginia Beach-New- port News, VA-NC	0.8574
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	1.5072
Alameda, CA Contra Costa, CA	
5790 Ocala, FL	0.9402
Marion, FL	
5800 Odessa-Midland, TX	0.9397
Ector, TX Midland, TX	
5880 Oklahoma City, OK	0.8900
Canadian, OK Cleveland, OK Logan, OK	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
McClain, OK Oklahoma, OK Pottawatomie, OK	
5910 Olympia, WA	1.0960
Thurston, WA	
5920 Omaha, NE-IA	0.9978
Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	
5945 Orange County, CA	1.1474
Orange, CA	
5960 Orlando, FL	0.9640
Lake, FL Orange, FL Osceola, FL Seminole, FL	
5990 Owensboro, KY	0.8344
Daviess, KY	
6015 Panama City, FL	0.8865
Bay, FL	
6020 Parkersburg-Marietta, WV- OH	0.8127
Washington, OH Wood, WV	
6080 Pensacola, FL	0.8814
Escambia, FL Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8739
Peoria, IL Tazewell, IL Woodford, IL	
6160 Philadelphia, PA-NJ	1.0713
Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9820
Maricopa, AZ Pinal, AZ	
6240 Pine Bluff, AR	0.7962
Jefferson, AR	
6280 Pittsburgh, PA	0.9365
Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	
6323 Pittsfield, MA	1.1288
Berkshire, MA	
6340 Pocatello, ID	0.9372
Bannock, ID	
6360 Ponce, PR	0.5169
Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	
6403 Portland, ME	0.9794
Cumberland, ME Sagadahoc, ME York, ME	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6440 Portland-Vancouver, OR- WA	1.0667
Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	
6483 Providence-Warwick-Paw- tucket, RI	1.0854
Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	
6520 Provo-Orem, UT	0.9879
Utah, UT	
6560 Pueblo, CO	0.9015
Pueblo, CO	
6580 Punta Gorda, FL	0.9218
Charlotte, FL	
6600 Racine, WI	0.9334
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9990
Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	
6660 Rapid City, SD	0.8846
Pennington, SD	
6680 Reading, PA	0.9295
Berks, PA	
6690 Redding, CA	1.1135
Shasta, CA	
6720 Reno, NV	1.0648
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1491
Benton, WA Franklin, WA	
6760 Richmond-Petersburg, VA ..	0.9477
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	1.1365
Riverside, CA San Bernardino, CA	
6800 Roanoke, VA	0.8614
Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	
6820 Rochester, MN	1.2139
Olmsted, MN	
6840 Rochester, NY	0.9194
Genesee, NY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9625
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9228
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1500
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9650
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9700
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.8021
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MOIL	0.8855
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	1.0367
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4623
Monterey, CA	
7160 Salt Lake City-Ogden, UT ...	0.9945
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8374
Tom Green, TX	
7240 San Antonio, TX	0.8753
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1131
San Diego, CA	
7360 San Francisco, CA	1.4142
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4145
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4741
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
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	1.1271
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0481
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3646
Santa Cruz, CA	
7490 Santa Fe, NM	1.0712
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3046
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9425
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9376
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton-Wilkes-Barre-Hazleton, PA	0.8599
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1474
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8462
Mercer, PA	
7620 Sheboygan, WI	0.9162
Sheboygan, WI	
7640 ShermanDenison, TX	0.9255
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8987
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9046
Woodbury, IA	
Dakota, NE	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
7760 Sioux Falls, SD	0.9257
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9802
St. Joseph, IN	
7840 Spokane, WA	1.0852
Spokane, WA	
7880 Springfield, IL	0.8659
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8424
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.1288
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8941
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8804
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0506
San Joaquin, CA	
8140 Sumter, SC	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9714
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.0940
Pierce, WA	
8240 Tallahassee, FL	0.8814
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9065
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8755
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8088
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9810
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9199
Shawnee, KS	
8480 Trenton, NJ	1.0432
Mercer, NJ	
8520 Tucson, AZ	0.8911
Pima, AZ	
8560 Tulsa, OK	0.8332
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8130
Tuscaloosa, AL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
8640 Tyler, TX	0.9521
Smith, TX	
8680 Utica-Rome, NY	0.8542
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA ..	1.3354
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1096
Ventura, CA	
8750 Victoria, TX	0.8756
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0031
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9840
Tulare, CA	
8800 Waco, TX	0.8073
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0851
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	0.8315
Black Hawk, IA	
8940 Wausau, WI	0.9782
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9939
Palm Beach, FL	
9000 Wheeling, WV-OH	0.7975
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9520

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8498
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8544
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1173
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9640
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0569
Yakima, WA	
9270 Yolo, CA	0.9840
Yolo, CA	
9280 York, PA	0.9026
York, PA	
9320 Youngstown-Warren, OH	0.9358
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0276
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8589
Yuma, AZ	

15. On page 50229, in Table 4H.—Pre-Reclassified Wage Index for Rural Areas, the table is corrected to read as follows:

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7660
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079
Louisiana	0.7567
Maine	0.8874

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Maryland	0.8946
Massachusetts	1.1288
Michigan	0.9000
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8021
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey ¹	
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island ¹	
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7821
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

¹ All counties within the State are classified as urban.

16. On page 50236, in Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay (LOS), the fourth column (DRG Title), line 59 (DRG 386) “Extreme Immaturity” is corrected to read “Extreme Immaturity or Respiratory Distress Syndrome Neonate”.

17. On page 50238, in Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay (LOS), the third column (Type), line 26 (DRG 473) “SURG” is corrected to read “MED”.

18. On pages 50264 through 50273, Table 9—Hospital Reclassifications and Redesignations by Individual Hospital—FY2003 is corrected by—

a. Adding the following entries (in numerical order):

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
130018	13	6340
240036	6980	5120

b. Deleting the following entries:

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
390197	0240	6160
390263	0240	6160
460011	46	6520

c. Correcting the standardized amount MSA reclassification for the following entries:

Provider No.	Actual MSA or rural area	Published standardized amount MSA reclassification	Corrected standardized amount MSA reclassification
340126	34	6640	6895
360175	36	1640	1840
470011	47	1123

d. Correcting the wage index MSA reclassification for the following entry:

Provider No.	Actual MSA or rural area	Published wage index MSA reclassification	Corrected wage index MSA reclassification
010005	01	3440	1000

19. On pages 50276 through 50285, the text beginning with section “I. Introduction” and ending with section “VIII. Impact of Policies Affecting Rural Hospitals” is corrected to read as follows:

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 Mandates 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 final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate the total impact of these changes for FY 2003 payments compared to FY 2002

payments to be approximately a \$300 million 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 Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in

certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the acute care hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and that the effects on some hospitals may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

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

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

costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

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

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 compensate hospitals adequately for their legitimate costs. In addition, we share the national goal of preserving the Medicare Trust Fund.

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 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, in the May 9, 2002 proposed rule, we solicited comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating payments.

We received several comments on the impact analysis for our May 9, 2002 proposed rule.

Comment: Several commenters noted that the effects of the proposed expansion to the postacute transfer policy were not included in the May 9, 2002 proposed rule impact tables. These commenters were concerned that the effect of implementing either of the two

proposed expansions of this policy would result in an overall decrease in per case payments in FY 2003.

Response: We did not analyze the postacute care transfer policy in the impact tables in the proposed rule because we did not propose a specific policy expansion. We did consider overall savings estimates attributable to the provision in the preamble discussion. Furthermore, we have not provided such an analysis in the impact tables in this final rule because we have decided not to make revisions to the postacute care transfer policy at this time. As stated elsewhere in the preamble, we will continue to assess whether further expansions or refinements of the transfer policy may be warranted for FY 2004 or subsequent years, and, if so, how to design such refinements and assess their impact.

Comment: Several commenters noted the impact that the large, legislated decreases in IME payments and the update factor (market basket increase minus 0.55 percentage point) will have on many hospitals. They argued that these decreases in payments, in combination with our proposals and an update factor of less than inflation, will have an even larger overall impact than indicated in our impact tables. The commenters indicated that, in a time when other health care costs are escalating due to nursing shortages, rising drug and technology costs, and "skyrocketing" professional and general insurance premiums, hospitals cannot absorb a reduction in inpatient Medicare payments. They argued that decreasing payments and increasing costs will make hospitals less able to make decisions based solely on the needs of the beneficiary and force them to make more decisions based on solvency.

Response: As the commenters pointed out, these reductions are legislated by Congress. However, as discussed further below, one of the biggest impacts on the changes in payments from FY 2002 to FY 2003 is the high total of outlier payments hospitals are receiving in FY 2002 (approximately 6.9 percent of total DRG payments) compared to the FY 2003 estimate of 5.1 percent. The net effect of this difference is to reduce the rate of change by 2.1 percentage points.

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 methodology for these hospitals. Among other short-term, acute care hospitals, only the 67 such hospitals in Maryland remain excluded from the acute care hospital inpatient prospective payment system under the waiver at section 1814(b)(3) of the Act.

There are approximately 631 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 hospital inpatient 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 July 2002, we have included 4,230 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

As of July 2002, there were 1,076 specialty hospitals excluded from the acute care hospital inpatient prospective payment system. Broken down by specialty, there were 486 psychiatric, 220 rehabilitation, 279 long-term care, 80 children's, and 11 cancer hospitals. In addition, there were 1,427 psychiatric units and 962 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 3.5 percent).

Inpatient rehabilitation facilities (IRF's) 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 final 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 estimate of the excluded hospital market basket (or 3.5 percent).

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect 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 Policy Changes Under the Hospital Inpatient Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the 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 \$300 million increase. We have prepared separate impact analyses of the 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 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 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 data 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 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 FY 2003 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the 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 GME and CRNAs.

- 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 changes, our analysis begins with a FY 2003 baseline simulation model using: the FY 2002 DRG GROUPEX (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 final 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 methodology 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 updating 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 3.5 percent minus 0.55 percentage points (for an update of 2.95 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) are also equal to the market basket increase of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent). We estimate the aggregate impact of this update will be to increase hospital payments by \$500 million.

A second significant factor that impacts changes in a hospital's 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. Because the impact of MGCRB reclassifications are budget neutral overall, the only impacts of these changes are on payments to individual hospitals and hospital groups.

A third significant factor is that we currently estimate that actual outlier payments during FY 2002 will be 6.9 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 average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2002 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2002 payments per case to estimated FY 2003 payments per case. We estimate FY 2002 payments will be approximately \$1.5 billion higher than if outlier payments had been 5.1 percent of total DRG payments.

Fourth, section 213 of Public Law 106-554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. 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 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 reduction will be to

decrease aggregate payments by \$1 billion.

Comment: Numerous commenters expressed concern about the statutory reduction to the IME formula multiplier for FY 2003 of 1.35. The commenters stated that this cut in IME reimbursement will have an extremely detrimental impact on the teaching hospital community.

Response: Congress establishes the IME formula multiplier for FY 2003 by law. Any changes to the multiplier must be made through the legislative process.

Comment: One commenter stated that the reduction to the IME formula multiplier was not considered in the impact analysis table (67 FR 31670) in the proposed rule. The commenter requested that the large impact due to reduction in IME payments be acknowledged and weighed against the cost to hospitals that would be incurred by the proposed outlier reduction, transfer payment expansion, and the removal of resident salary costs from the wage index.

Response: In the May 9, 2002 proposed rule at 67 FR 31670 and 31671, we included several footnotes that explain the various calculations in the impact analysis for FY 2003. Footnote number 9 states that the impact of the reduction in IME adjustment payments is reflected in column 8 of the table, which contains all FY 2003 changes. Thus, we have incorporated the reduction to the IME formula multiplier in the impact analysis of total Medicare hospital expenditures for FY 2003, and have similarly done so in this final rule.

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 a hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003. We estimate the higher DSH payments will increase overall Medicare payments to hospitals by \$200 million.

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 4,230 hospitals included in the analysis. This number is 555 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 2,620 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,519 hospitals located in large urban areas (populations over 1 million), and 1,101 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,610 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 2,650, 1,576, 1,074, and 1,580, 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 3,119 nonteaching hospitals in our analysis, 870 teaching hospitals with fewer than 100 residents, and 241 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 (160), SCHs (526), MDHs (241), and hospitals that are both SCH and RRC (76) shown

here were not reclassified for purposes of the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1999 Medicare cost report files, if available (otherwise FY 1998 data are used). Data

needed to determine ownership status were unavailable for 177 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 126 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]

	Num. of Hosps. ¹	DRG changes ²	New wage data ³	Remove GME & CRNA 80/20 ⁴	Remove GME & CRNA 100 percent ⁵	DRG & WI changes ⁶	MGCRB reclassification ⁷	All FY 2003 changes ⁸
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
By Geographic Location:								
All hospitals	4,230	0.4	0.0	0.0	0.1	0.0	0.0	0.4
Urban hospitals	2,620	0.5	0.0	0.0	0.1	0.0	-0.5	0.2
Large urban areas (populations over 1 million)	1,519	0.4	0.0	0.0	0.0	-0.1	-0.5	0.2
Other urban areas (populations of 1 million or fewer)	1,101	0.5	0.0	0.1	0.1	0.1	-0.4	0.7
Rural hospitals	1,610	0.1	0.2	0.1	0.1	-0.2	2.5	1.9
Bed Size (Urban):								
0-99 beds	645	0.3	0.0	0.1	0.1	0.0	-0.6	1.3
100-199 beds	909	0.3	-0.2	0.1	0.1	-0.3	-0.5	0.8
200-299 beds	523	0.5	0.0	0.1	0.1	0.0	-0.4	0.4
300-499 beds	398	0.6	-0.2	0.0	0.1	0.0	-0.4	-0.1
500 or more beds	145	0.6	0.2	0.0	0.0	0.2	-0.6	-0.6
Bed Size (Rural):								
0-49 beds	747	-0.3	0.3	0.1	0.1	-0.5	0.5	2.2
50-99 beds	501	-0.1	0.2	0.1	0.1	-0.3	0.9	2.1
100-149 beds	215	0.1	0.3	0.1	0.1	-0.1	2.9	1.9
150-199 beds	78	0.2	0.2	0.1	0.1	0.0	4.9	1.8
200 or more beds	69	0.6	0.1	0.1	0.1	0.2	4.0	1.4
Urban by Region:								
New England	135	0.3	-0.1	0.1	0.1	0.6	-0.1	-0.2
Middle Atlantic	404	0.6	-0.4	0.0	-0.1	-0.5	0.0	-1.3
South Atlantic	384	0.5	0.0	0.1	0.1	0.0	-0.6	0.7
East North Central	429	0.5	0.1	0.0	0.1	0.0	-0.5	0.3
East South Central	159	0.4	-0.1	0.0	0.0	-0.3	-0.7	0.7
West North Central	178	0.5	0.2	0.1	0.1	0.3	-0.7	0.7
West South Central	335	0.5	0.5	0.0	0.0	0.3	-0.7	1.0
Mountain	132	0.7	0.5	0.1	0.1	0.8	-0.6	1.7
Pacific	417	0.3	-0.3	0.1	0.2	-0.3	-0.5	0.0
Puerto Rico	47	0.3	-0.8	0.0	0.0	-0.7	-0.9	0.6
Rural by Region:								
New England	40	0.2	0.2	0.0	0.0	-0.2	-2.8	0.9
Middle Atlantic	67	0.1	-0.5	0.0	0.0	-1.0	2.7	1.2
South Atlantic	232	0.1	0.1	0.1	0.1	-0.3	2.9	1.5
East North Central	215	0.3	0.1	0.1	0.1	-0.1	2.4	2.4
East South Central	239	-0.1	0.7	0.1	0.1	0.2	2.5	2.0
West North Central	279	0.3	0.4	0.0	0.0	0.2	1.6	2.2
West South Central	285	-0.1	0.3	0.1	-0.3	3.3	1.9	
Mountain	145	0.2	0.1	0.0	0.0	-0.3	1.2	2.0
Pacific	103	0.1	0.3	0.1	0.1	-0.1	2.3	2.0
Puerto Rico	5	0.1	-5.4	0.1	0.1	-5.6	-0.7	-2.7
By Payment Classification:								
Urban hospitals	2,650	0.5	0.0	0.0	0.1	0.0	-0.4	0.2
Large urban areas (populations over 1 million)	1,576	0.4	-0.1	0.0	0.0	-0.1	-0.4	-0.2
Other urban areas (populations of 1 million or fewer)	1,074	0.5	0.0	0.1	0.1	0.1	-0.5	0.7
Rural areas	1,580	0.1	0.2	0.1	0.1	-0.2	2.3	1.9
Teaching Status:								
Non-teaching	3,119	0.3	0.0	0.1	0.1	-0.1	0.3	1.3
Fewer than 100 Residents	870	0.6	-0.1	0.0	0.1	0.0	-0.3	0.5
100 or more Residents	241	0.5	0.0	0.0	0.0	0.0	-0.3	-1.3
Urban DSH:								
Non-DSH	1,549	0.6	0.0	0.0	0.1	0.0	0.2	0.6

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2003—Continued
 [Operating prospective payment system, [percent changes in payments per case]

	Num. of Hosp. ¹	DRG changes ²	New wage data ³	Remove GME & CRNA 80/20 ⁴	Remove GME & CRNA 100 percent ⁵	DRG & WI changes ⁶	MGCRB reclassification ⁷	All FY 2003 changes ⁸
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
100 or more beds	1,361	0.4	0.0	0.0	0.1	-0.1	-0.5	0.1
Less than 100 beds	286	0.0	0.1	0.1	0.1	-0.3	-0.4	1.3
Rural DSH:								
Sole Community (SCH)	470	-0.2	0.2	0.1	0.1	-0.5	0.2	2.1
Referral Center (RRC)	156	0.2	0.3	0.1	0.1	0.0	4.7	1.5
Other Rural:								
100 or more beds	76	0.0	0.3	0.1	0.1	-0.1	1.3	1.7
Less than 100 beds	332	-0.2	0.4	0.1	0.1	-0.2	0.6	2.1
Urban teaching and DSH:								
DSH	757	0.5	-0.1	0.0	0.0	0.0	-0.6	-0.4
Teaching and no DSH	284	0.7	0.0	0.0	0.0	0.1	0.0	-0.1
No teaching and DSH	890	0.3	0.0	0.1	0.1	-0.1	-0.4	1.2
No teaching and no DSH	719	0.5	-0.1	0.1	0.1	0.0	-0.4	0.8
Rural Hospital Types:								
Non special status hospitals	577	-0.1	0.4	0.1	0.1	-0.1	1.2	1.9
RRC	160	0.3	0.2	0.1	0.1	0.1	6.1	1.1
SCH	526	-0.1	0.2	0.0	0.0	-0.5	0.2	2.1
Medicare-dependent hospitals (MDH)	241	-0.2	0.4	0.1	0.1	-0.3	0.6	2.4
SCH and RRC	76	0.5	0.1	0.0	0.0	0.0	1.3	2.5
Type of Ownership:								
Voluntary	2,461	0.5	0.0	0.0	0.1	0.0	-0.1	0.4
Proprietary	723	0.4	0.1	0.1	0.1	0.0	-0.1	0.4
Government	869	0.2	0.2	0.1	0.1	-0.1	0.2	0.6
Unknown	177	0.4	-0.2	0.0	0.1	-0.3	-0.5	0.3
Medicare Utilization as a Percent of Inpatient Days:								
0-25	310	0.3	-0.1	0.1	0.1	-0.3	-0.3	-0.6
25-50	1,613	0.5	0.0	0.0	0.1	0.0	-0.3	0.1
50-65	1,677	0.4	0.0	0.1	0.1	0.0	0.3	1.0
Over 65	504	0.3	-0.1	0.0	0.1	-0.3	0.6	0.6
Unknown	126	0.9	0.1	0.0	0.0	0.3	-0.7	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2003 Reclassifications:								
All Reclassified Hospitals	628	0.4	0.0	0.1	0.1	0.0	4.6	1.1
Standardized Amount Only	28	0.2	-0.1	0.1	0.1	-0.3	1.3	0.9
Wage Index Only	521	0.4	0.1	0.1	0.1	0.0	4.7	0.7
Both	38	0.4	0.0	0.1	0.1	-0.1	6.5	0.8
Non-reclassified Hospitals	3,605	0.4	0.0	0.0	0.1	0.0	-0.7	0.3
All Reclassified Urban Hospitals	113	0.6	-0.2	0.0	0.1	0.1	4.6	0.1
Standardized Amount Only	11	0.2	-0.9	0.1	0.1	-1.2	0.7	0.2
Wage Index Only	87	0.7	-0.2	0.0	0.0	0.2	4.8	-0.1
Both	15	0.5	0.2	0.1	0.2	0.4	5.9	3.1
Urban Non-reclassified Hospitals	2,473	0.5	0.0	0.0	0.1	0.0	-0.7	0.2
All Reclassified Rural Hospitals	515	0.3	0.2	0.1	0.1	0.0	4.6	1.7
Standardized Amount Only	11	0.5	0.4	0.1	0.1	0.4	5.3	3.2
Wage Index Only	485	0.3	0.2	0.1	0.1	0.0	4.5	1.7
Both	19	0.3	-0.1	0.1	0.1	-0.3	7.3	1.7
Rural Non-reclassified Hospitals	1,094	-0.1	0.3	0.1	0.1	-0.3	-0.6	2.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	-0.1	-0.2	0.0	0.0	-0.9	-1.3	2.7

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 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.

³ This column displays the impact of updating the wage index with wage data from hospitals' FY 1999 cost reports.

⁴ This column displays the impact of an 80/20 percent blend of removing the labor costs and hours associated with graduate medical education (GME) and for the Part A costs of certified registered nurse anesthetists (CRNAs).

⁵ This column displays the impact of completely removing the labor costs and hours associated with GME and for the Part A costs of CRNAs.

⁶ This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, the 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 1, 2, 3 and 4, and the FY 2003 budget neutrality factor of 0.993209.

⁷ 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.

⁸This column shows changes in payments from FY 2002 to FY 2003. It incorporates all of the changes displayed in columns 5 and 6 (the changes displayed in columns 1, 2, 3, and 4 are included in column 5). 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 Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2002 DRG relative weights (GROUPEL version 19.0) to aggregate payments using the FY 2003 DRG relative weights (GROUPEL version 20.0). We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 0.993209 is applied to payments in Column 5. 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 making will result in 0.4 percent higher payments to hospitals overall. This effect is largely attributable to the anticipated higher payments after April 28, 2003, for drug-eluting stents, as described in section II.B. of this final rule. Specifically, we created two new DRGs (526 and 527) to be effective April 28, 2003. The relative weights for these new DRGs are 14 and 16 percent higher, respectively, than the weights for current DRGs 516 and 517, the current DRGs for stents. Hospitals that are currently doing these procedures demonstrate positive impacts from this change.

Another change is to DRGs 14 (retitled, Intracranial Hemorrhage and Stroke with Infarction) and 15 (retitled, Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction), and new DRG 524 (Transient Ischemia). With the new configuration of these DRGs, over 100,000 cases that previously would have been assigned to DRG 14 (with a FY 2003 relative weight of 1.2943) will now be assigned to DRG

15 (with a FY 2003 relative weight of 0.9858).

Urban hospitals with 300 or more beds, and rural hospitals with 200 or more beds benefit from these changes. Rural hospitals with fewer than 50 beds would experience a 0.3 percent decrease due to these changes, and rural hospitals with between 50 and 99 beds would experience a 0.1 percent decrease. Among rural hospitals categorized by region, the East South Central and West South Central would experience a 0.1 percent decrease in payments. Among special rural hospital categories, SCHs would experience a 0.1 percent decrease and MDHs would experience a 0.2 percent decrease.

C. Impact of Wage Index Changes (Columns 2, 3, and 4)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the 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 1, the impact of the new data on hospital payments is isolated in columns 2, 3, and 4 by holding the other payment parameters constant in the three simulations. That is, columns 2, 3, and 4 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 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 2 shows the impacts of updating the wage data using FY 1999 cost reports. This column maintains the same 60/40 phaseout 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 5.4 percent decrease). Rural hospitals in the East South Central region experience the next largest impact, a 0.7 percent increase. Among urban hospitals, Puerto Rico and the Middle Atlantic regions would experience a 0.8 and 0.4 percent decreases, respectively. The Mountain region would experience a 0.5 percent increase.

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 have been the fourth year of the phaseout. This would have meant 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 of these data removed, and FY 2004 would begin the calculation with 100 percent of these data removed. However, we are removing 100 percent of GME and CRNA costs from the FY 2003 wage index. To demonstrate the impacts of this provision, we first show the impacts of moving to a wage index with 80 percent of these data removed (Column 3), then show a wage index with 100 percent of these data removed (Column 4). 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 0.2 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 no change in payments.

We note that the wage data used for the final wage index are based upon the data available as of July 2002 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date.

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 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 (344) experience less than a 5-percent change. A total of 10 labor market areas experience an increase of more than 5

percent and less than 10 percent. Three areas experience an increase greater than 10 percent. A total of 15 areas

experience decreases of more than 5 percent and less than 10 percent.

Finally, 1 area experiences a decline 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	3
Increase more than 5 percent and less than 10 percent	26	10
Increase or decrease less than 5 percent	335	344
Decrease more than 5 percent and less than 10 percent	10	15
Decrease more than 10 percent	1	1

Among urban hospitals, 42 would experience an increase of between 5 and 10 percent and 9 more than 10 percent. A total of 22 rural hospitals have increases greater than 5 percent, but none have greater than 10-percent increases. On the negative side, 55

urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Two urban hospitals have decreases in their wage index values greater than 10 percent. There are 17 rural hospitals with decreases in their wage index values

greater than 5 percent but less than 10 percent. There are no rural hospitals with decreases in their wage index value greater 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	9	0
Increase more than 5 percent and less than 10 percent	42	22
Increase or decrease less than 5 percent	2565	1985
Decrease more than 5 percent and less than 10 percent	55	17
Decrease more than 10 percent	2	0

D. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 5)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared simulated aggregate payments using the FY 2002 DRG relative weights and wage index to simulated aggregate payments using the FY 2003 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.D. of this final rule, we are approving one new technology for add-on payments in FY 2003. We estimate the total add-on payments for this new technology will be \$74.8 million.

We computed a wage and recalibration budget neutrality factor of 0.993209. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 5. The 0.0 percent impact for all hospitals demonstrates that these

changes, in combination with the budget neutrality factor, are budget neutral.

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 1, 2, 3, and 4. It is included in the impacts shown in column 5.

The changes in this column are the sum of the changes in columns 1, 2, 3, and 4, combined with the budget neutrality factor and the wage index floor for urban areas. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

E. Impact of MGCRB Reclassifications (Column 6)

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 final 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.

Section 1886(d)(8)(D) of the Act requires that the overall effect of geographic reclassification is budget neutral. Therefore, we applied an adjustment of 0.991095 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments 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 0.4 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.

Geographic reclassification has a positive impact on most of the rural hospital groups. The smallest increases among the rural census divisions are 1.2 and 1.6 percent for Mountain and West North Central regions, respectively. The largest increases are in the rural South Atlantic and West South Central regions. These regions receive increases of 2.9 and 3.3 percent, respectively.

Among all the hospitals that were reclassified for FY 2003 (including hospitals that received wage index reclassifications in FY 2001 or FY 2002 that extend for 3 years), the MGCRB changes are estimated to provide a 4.6 percent increase in payments. Urban hospitals reclassified for FY 2003 are expected to receive an increase of 4.6 percent, while rural reclassified hospitals are also 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 1.3 percent is expected, while those reclassified for purposes of the wage index only show a 4.7 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.7 for urban hospitals and 0.6 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 1.3 percent.

F. All Changes (Column 7)

Column 7 compares our estimate of payments per case, incorporating all changes reflected in this final 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. Because the reclassifications shown in column 6 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.

Column 7 includes the effects of the 2.95 percent update to the standardized amounts and the hospital-specific rates

for MDHs and SCHs. It also reflects the 1.8 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 (6.9 percent), as described in the introduction to this Appendix and the Addendum to this final 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 7 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 7 may not equal the sum of the changes in columns 5 and 6, 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. Hospitals in urban areas experience a 0.2 percent increase in payments per case compared to FY 2002. Meanwhile, hospitals in rural areas experience a 1.9 percent payment increase. Hospitals in large urban areas experience a 0.2 percent decline in payments, largely due to the 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 1.3 percent.

Among urban census divisions, the largest payment increase was 1.7 percent in the Mountain region. Hospitals in the urban Middle Atlantic would experience an overall decrease of 1.3 percent and hospitals in the New England region would experience a decrease of 0.2 percent. These reductions are primarily due to the combination of the negative impact on these hospitals of reducing IME and the lower outlier payments during FY 2003. The only rural hospital category experiencing overall payment decreases is Puerto Rico, where payments decrease by 2.7 percent, largely due to the updated wage index data. In the rural East North Central region, payments appear to increase by 2.4 percent. The rural West North Central regions also benefited with a 2.2 percent increase.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 2.1 percent, 2.4 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 as do hospitals paid based on the national standardized amounts.

Hospitals that were reclassified for FY 2003 are estimated to receive an overall 1.1 percent increase in payments. Urban hospitals reclassified for FY 2003 are anticipated to receive an increase of 0.1 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 1.7 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 0.9 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 0.7 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 2.7 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003
Operating prospective payment system, payments per case

	Num. of hosps.	Average FY 2002 payment per case ¹	Average FY 2003 payment per case ¹	All FY 2003 changes
	(1)	(2)	(3)	(4)
By Geographic Location:				
All hospitals	4,230	7,218	7,248	0.4
Urban hospitals	2,620	7,718	7,731	0.2
Large urban areas (populations over 1 million)	1,519	8,269	8,253	-0.2
Other urban areas (populations of 1 million of fewer)	1,101	7,002	7,053	0.7
Rural hospitals	1,610	5,168	5,265	1.9
Bed Size (Urban):				
0-99 beds	645	5,309	5,378	1.3
100-199 beds	909	6,424	6,477	0.8
200-299 beds	523	7,394	7,425	0.4
300-499 beds	398	8,345	8,336	-0.1
500 or more beds	145	10,007	9,948	-0.6
Bed Size (Rural):				
0-49 beds	747	4,260	4,353	2.2
50-99 beds	501	4,776	4,875	2.1
100-149 beds	215	5,106	5,204	1.9
150-199 beds	78	5,515	5,613	1.8
200 or more beds	69	6,750	6,846	1.4
Urban by Region:				
New England	135	8,224	8,206	-0.2
Middle Atlantic	404	8,789	8,672	-1.3
South Atlantic	384	7,311	7,364	0.7
East North Central	429	7,293	7,315	0.3
East South Central	159	6,956	7,004	0.7
West North Central	178	7,358	7,407	0.7
West South Central	335	7,103	7,175	1.0
Mountain	132	7,417	7,543	1.7
Pacific	417	9,386	9,390	0.0
Puerto Rico	47	3,319	3,340	0.6
Rural by Region:				
New England	40	6,405	6,460	0.9
Middle Atlantic	67	5,267	5,328	1.2
South Atlantic	232	5,245	5,325	1.5
East North Central	215	5,139	5,264	2.4
East South Central	239	4,746	4,841	2.0
West North Central	279	5,223	5,340	2.2
West South Central	285	4,536	4,620	1.9
Mountain	145	5,789	5,905	2.0
Pacific	103	6,652	6,785	2.0
Puerto Rico	5	2,753	2,679	-2.7
By Payment Classification:				
Urban hospitals	2,650	7,703	7,716	0.2
Large urban areas (populations over 1 million)	1,576	8,196	8,183	-0.2
Other urban areas (populations of 1 million of fewer)	1,074	7,027	7,077	0.7
Rural areas	1,580	5,155	5,252	1.9
Teaching Status:				
Non-teaching	3,119	5,890	5,964	1.3
Fewer than 100 Residents	870	7,475	7,513	0.5
100 or more Residents	241	11,352	11,202	-1.3
Urban DSH:				
Non-DSH	1,549	6,567	6,604	0.6
100 or more beds	1,361	8,296	8,302	0.1
Less than 100 beds	286	5,168	5,233	1.3
Rural DSH:				
Sole Community (SCH)	470	4,942	5,048	2.1
Referral Center (RRC)	156	5,974	6,061	1.5
Other Rural:				
100 or more beds	76	4,517	4,592	1.7
Less than 100 beds	332	4,089	4,175	2.1
Urban teaching and DSH:				
Both teaching and DSH	757	9,177	9,144	-0.4
Teaching and no DSH	284	7,773	7,766	-0.1
No teaching and DSH	890	6,535	6,611	1.2
No teaching and no DSH	719	6,041	6,089	0.8
Rural Hospital Types:				
Non special status hospitals	577	4,261	4,344	1.9

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003—Continued
Operating prospective payment system, payments per case

	Num. of hosps.	Average FY 2002 payment per case ¹	Average FY 2003 payment per case ¹	All FY 2003 changes
	(1)	(2)	(3)	(4)
RRC	160	5,677	5,740	1.1
SCH	526	5,280	5,393	2.1
Medicare-dependent hospitals (MDH)	241	4,048	4,146	2.4
SCH and RRC	76	6,626	6,794	2.5
Type of Ownership:				
Voluntary	2,461	7,342	7,370	0.4
Proprietary	723	6,945	6,971	0.4
Government	869	6,809	6,850	0.6
Unknown	177	7,302	7,321	0.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	310	9,845	9,790	–0.6
25–50	1,613	8,267	8,271	0.1
50–65	1,677	6,257	6,318	1.0
Over 65	504	5,647	5,682	0.6
Unknown	126	8,992	9,015	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals	628	6,530	6,603	1.1
Standardized Amount Only	28	5,971	6,026	0.9
Wage Index Only	521	6,749	6,798	0.7
Both	38	5,901	5,950	0.8
All Nonreclassified Hospitals	3,605	7,327	7,353	0.3
All Urban Reclassified Hospitals	113	8,610	8,618	0.1
Urban Nonreclassified Hospitals	11	5,794	5,807	0.2
Standardized Amount Only	87	9,211	9,199	–0.1
Wage Index Only	15	5,870	6,050	3.1
Both	2,473	7,690	7,702	0.2
All Reclassified Rural Hospitals	515	5,721	5,819	1.7
Standardized Amount Only	11	4,848	5,003	3.2
Wage Index Only	485	5,728	5,826	1.7
Both	19	5,875	5,977	1.7
Rural Nonreclassified Hospitals	1,094	4,516	4,611	2.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	4,894	5,024	2.7

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

Table II presents the projected impact of the 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 7 of Table I.

VII. Impact of Specific Policy Changes

A. Impact of Changes Relating to EMTALA Provisions

We will address the proposed changes relating to the EMTALA provisions in a separate final rule to be published at a later date.

B. Impact of Policy Changes Relating to Provider-Based Entities

In section V.K. of the preamble of this final rule, we discuss our 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 an orderly and uniform implementation strategy once the grandfathering provision for these entities expires on September 30, 2002.

Because we believed it would be difficult to quantify the impact of these changes, in the May 9, 2002 proposed rule, we solicited comments on these issues.

We faced two problems that prevented us from developing quantitative impact estimates. First, we do not know what level of inappropriate billing is now occurring. We know from anecdotal evidence that, in the past,

many hospitals began billing for services of additional facilities as provider-based without seeking CMS approval or even notifying CMS of the existence of the facilities. While some of these facilities may have met provider-based criteria, others undoubtedly did not. Because we do not know what percentage of current payments to hospitals may be due to inappropriate billing, we do not have a baseline to use in projecting future savings from the revised regulations. Moreover, hospitals may furnish similar services at several locations but are not required to identify services at their various locations separately on their bills. Thus, even if a hospital voluntarily stops billing for a particular location's services as hospital services, it will be difficult to determine conclusively whether the reduction in payments resulted from this action or from unrelated factors, such as changes in utilization.

As noted above, we attempted to solicit assistance from commenters in

dealing with the issue of determining the impact of these changes. However, we did not receive any comments that would help resolve this issue. Thus, we remain unable to accurately determine the number of cases that would be determined not to be provider-based or to estimate the dollar impact of these determinations.

VIII. Impact of Policies Affecting Rural Hospitals

A. Raising the Threshold To Qualify for the CRNA Pass-Through Payments

In section V. of the preamble of this final rule, we are raising 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. We have identified 622 hospitals that currently 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 will receive pass-through payments. That is, another approximately 600 rural hospitals have similar volumes to hospitals that currently receive the pass-through. However, because in order to be eligible to receive pass-through payments, the hospital must employ the CRNA and the CRNA must agree not to bill for services under Part B, we estimate that half the hospitals that would otherwise qualify based on volume of procedures are not eligible because they either do not employ the CRNA or the CRNA does not 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 (the CRNA is employed by the hospital and the CRNA does not bill for Part B), 45 additional hospitals would now be eligible for these pass-through payments under this change.

B. Removal of Requirement for CAHs To Use State Resident Assessment Instrument

In section VII. of the preamble of this final rule, we are eliminating the requirement that CAHs use the State resident assessment instrument (RAI) to conduct patient assessments. There are approximately 630 CAHs. The overwhelming majority of CAHs, 95 percent, or approximately 598 CAHs, provide SNF level care. The elimination

of the requirement to use the State RAI will greatly reduce the burden on CAHs because facilities will 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 will reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

C. Exclusion of Limited-Service Specialty Hospitals From the Definition of Like Hospitals for Purposes of Granting SCH Status

Section 1886(d)(5)(D)(iii) of the Act provides that, to qualify as an SCH, a hospital must be more than 35 road miles from another hospital. In addition, there are several other conditions under which a hospital may qualify as an 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 hospital” refers to a hospital 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 an 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, an 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. To prevent a hospital from losing its SCH status in such a situation, we are establishing criteria whereby a limited-service specialty hospital may be excluded from the definition of “like hospital”. To determine whether a hospital qualifies as an SCH, the fiscal intermediary will make a determination whether a nearby hospital paid under the acute care hospital inpatient prospective payment

system is a like hospital by comparing the total acute inpatient days of the SCH applicant hospital with the total acute inpatient days of the nearby hospital. If the total acute inpatient days of the nearby hospital are greater than 8 percent of the total inpatient days reported by the SCH applicant hospital, the hospital is considered a like hospital for purposes of evaluating the application for SCH status. If the total acute inpatient days of the nearby hospital are 8 percent or less of the total acute inpatient days of the applicant hospital, the nearby hospital is not considered a like hospital for purposes of evaluating the application for SCH status under § 412.92.

The impact of this change would be: To allow some hospitals that are currently SCHs but whose status is jeopardized by the opening of a limited-service specialty hospital to retain their status; to allow hospitals that are applying for SCH status to exclude existing limited-service specialty hospitals from the list of like hospitals in their service area; or to allow some hospitals that previously lost their SCH status due to a specialty hospital opening in their service area to regain that status. We note that this change is effective for cost reporting periods beginning on or after October 1, 2002. Therefore, hospitals that lost their SCH status and are able to regain that status as a result of this change cannot have that status applied retroactively to prior periods.

We are unable to quantify precisely the impact of this policy change. However, we anticipate it will be minimal because we believe the criteria we have established will limit the application of this policy. We do not anticipate more than approximately 10 situations that will be affected by this change during FY 2003.

IX. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice take effect. However, we can waive this procedure, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and the reasons for it into the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the preamble language of the final rule. In this notice, the technical corrections include

comments and responses that were inadvertently omitted from the August 1, 2002 final rule. We have incorporated these comments and responses into this correction notice to assure the commenters that we received their comments on the proposed rule and that their comments were given full consideration before publication of the final rule. Additional technical corrections include, corrections to entries in various tables and charts, replacing data inadvertently published with the correct data, and also making a variety of grammatical corrections. These corrections are necessary to

ensure that the final rule accurately reflects our prospective payment methodology and rates. In addition, these corrections ensure that correct wage index values are used to calculate payments to hospitals. In light of the very technical nature of these corrections, notice-and-comment procedures are both unnecessary and impracticable. Therefore, we find good cause to waive notice and comment procedures.

In addition, the Administrative Procedure Act (APA) normally requires a 30-day delay in the effective date of a final rule. Because this notice simply

makes technical modifications to a final rule that has previously gone through notice-and-comment rulemaking, we believe good cause also exists under APA to waive the 30-day delay in the effective date.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 17, 2003.

Ann C. Agnew,

Executive Secretary to the Department.

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